Agency Strategic Plan

Department Of Medical Assistance Services

Agency Mission, Vision, and Values

Mission Statement:

To provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians.

Agency Vision:

DMAS will become a recognized leader in the administration of health care programs in Virginia and among state Medicaid agencies.

Agency Values:

- **Operate with a high degree of customer service.**
- **Demonstrate integrity, respect, responsiveness and competency in our actions and communications.**
- **Foster an atmosphere of effective collaboration with our customers and stakeholders.**
- **Encourage innovation and require accountability.**

Agency Executive Progress Report

Current Service Performance

Governor Warner's priority objective for the Department of Medical Assistance Services (DMAS) was to increase enrollment in Virginia's health insurance programs for children. DMAS has met this challenge. As a result of administrative and operational improvements in the programs and intense outreach efforts, an additional 130,000 children have been enrolled in either Medicaid or the Family Access to Medical Insurance Security (FAMIS) program. Based on current estimates, 96% of the children eligible for these programs are now insured.

In addition to turning around children's health insurance, DMAS has been working to make Medicaid a more cost-effective program. Pharmacy expenditures represented the fastest growing component of Medicaid spending in previous years. To control these costs, DMAS successfully implemented several cost-containment programs that reduced the annual increase in prescription drug costs from 12% to 3%. Equally important, our customers continue to receive high quality prescription drug coverage. Also, DMAS currently is expanding its managed care programs to additional customers in order to control costs and improve quality of care. Other programs that are being implemented to improve the level and quality of services provided to our customers include a new pediatric dental program, a disease state management program, and new and expanded programs for special populations, known as "waiver programs."

DMAS also has been working diligently to improve its customer service. We have made great strides in working with and involving various stakeholders (e.g., providers and advocacy groups) in the development and implementation of agency programs and activities. In addition, the performance of the agency's call center has improved markedly in the past year, which enables the agency to provide better customer service to providers and enrollees.

For the future, the agency and the Commonwealth's resources dedicated to its programs will continue to be pressed. In 1995, Virginia Medicaid provided coverage to approximately 681,000 recipients, representing about 27% of all persons who lived below 200% of the federal poverty level (FPL). Within ten years, coverage increased to include more than 852,000 recipients, representing approximately 30% of all persons living below 200% FPL. Efforts to control costs while maintaining quality health care coverage will continue to be a high priority for the Department

Productivity

DMAS strives to be an efficient and effective organization. Currently, DMAS uses several high level measures to track the overall productivity of our agency. These measures well-illustrate DMAS' increased efficiency in recent years.

Note: Each measure described in this section has a graphic component that can be found in Appendix B.

Medicaid Recipients per DMAS Employee

Purpose and explanation: This statistic shows the number of people actually receiving services in a given year in the Medicaid program compared to the maximum number of DMAS employees, as measured by the maximum employment level (MEL).

Results: This measure has increased from 1,828 recipients per employee in FY 1998 to 2,358 in FY 2005. This is a 29.0% overall increase in customers per employee in the seven year period. With the number of employees remaining relatively constant, this illustrates our overall increased efficiency of work over this period.

Net Administrative Expenditures per Total Expenditures

Purpose and explanation: This measure shows Medicaid administrative expenditures by year compared to the total Medicaid expenditures.

The net administrative expenditures exclude highly variable expenditures of transportation (which actually is a program service/benefit provided directly to clients) and information technology (expenses were unusually and significantly higher during the past few years due to the design and implementation of an entirely new Medicaid Management Information System - MMIS). Both sets of expenditures also exclude the intergovernmental transactions (IGT)/ revenue maximization.

Results: Net administrative expenditures per total expenditures have decreased from 2.03% in FY 1999 to 1.31% in FY 2005. This reflects a 35.6% decrease in this important overall measure. We are efficiently using our resources.

Medical Expenditures per Net Administrative Expenditures

Purpose and explanation: This measure is similar to the above; however, it illustrates the ratio of medical expenditures only to the net administrative expenditures, defined above.

Results: Medical expenditures to net administrative expenditures have increased from a factor of 48.2 in FY 1999 to a factor of 75.3 in FY 2005. This is a 56.4% increase.

Managed Care Enrollment per Managed Care Staff

Purpose and explanation: This measure compares the enrollment in DMAS' two managed care plans, MEDALLION and Medallion II, with the dedicated resources in the Managed Care Division. A significant focus of DMAS' efforts over the years has been to move more of our clients to managed care plans.

Results: In FY 2000, the enrollment in managed care per staff member was over 13,000. Today, in 2005, the managed care enrollment per staff has grown to over 22,000, or a 66% growth.

Home and Community Based Care Waiver Enrollment per Long Term Care Staff

Purpose and explanation: This measure compares recipients in the Home and Community Based Care waivers to the number of staff dedicated to the Home and Community Based Care waivers.

Results: In FY 2000, there were 1,400 recipients in the Elderly or Disabled with Consumer Direction Waiver, or the AIDS waiver for every dedicated staff person. In 2004, the enrollment per staff had grown to over 1,809, or a 29% growth.

Major Initiatives and Related Progress

The Medicaid program is very large and complex and has many different components and activities. DMAS is in the process of implementing several major initiatives to improve the quality and cost-effectiveness of Medicaid as well as FAMIS.

Behavioral Pharmacy Management Services (BPMS)

The Department's newest pharmacy quality initiative evaluates the quality of care being provided to recipients receiving behavioral health medication. The program identifies prescribing patterns that appear to deviate from best practices. Providers are informed of the variations that relate to their patients and are offered expert consultation, if desired. The initial analysis of behavioral pharmacy claims resulted in letters being sent to outlier prescribes that involved over 37,000 recipients (39% of all recipients receiving designated behavioral health medications), and more than $17 million in drug spending (40% of total spending for these drugs). It is too early to identify any specific quality interventions or savings; however, the Department is very confident this program will be successful.

Smiles for Children Dental Program

DMAS is implementing the new Smiles for Children dental program that consolidates dental services provided to Medicaid and FAMIS children under a single administrator to improve access to and utilization of pediatric dental services. The new program responds to the concerns of the dental provider community and the recommendations of the 2003 Virginia Dental Health Summit, both of which strongly advocated for the new program structure. The new program design and a 30% increase in dental fees approved by the Governor and General Assembly are expected to increase provider participation and improve access to dental care. The initial results indicate that 120 new providers have joined the program. DMAS is confident the network will continue to expand in the coming months.

FAMIS MOMS

Effective August 1, 2005, DMAS will implement a new program called FAMIS MOMS that will expand Virginia's Title XXI program to pregnant women. The 2005 General Assembly appropriated funding to expand coverage from the current Medicaid income level (133% FPL) to 150% FPL. Women enrolled in FAMIS MOMS will receive Medicaid benefits for the duration of their pregnancies and for two months postpartum. Women can apply for FAMIS MOMS by phone through the FAMIS Central Processing Unit (CPU), on-line at www.FAMIS.org, or through their local departments of social services. Most women will receive medical services from a contracted managed care organization and early and continuous prenatal care will be strongly encouraged.

Long Term Care Waivers

As a result of actions taken by the 2005 General Assembly, DMAS is implementing two new waiver programs, a Day Support Waiver and Alzheimer's Waiver. The Day Support Waiver, which was implemented on July 1, 2005, provides day support and prevocational services to 300 people with mental retardation who could otherwise be admitted to Intermediate Care Facilities for the Mentally Retarded. The Alzheimer's Assisted Living Waiver provides services in assisted living facilities for 200 people who are 55 and older, who have Alzheimer's, who receive an Auxiliary Grant, and who might otherwise be admitted to nursing facilities. The Alzheimer's Waiver is expected to be implemented in the next few months.

Medicare Part D

The federal Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) established a new Medicare beneficiary drug benefit (Part D) that becomes effective on January 1, 2006. As a result of this

program, approximately 120,000 current recipients enrolled in both Medicare and Medicaid (dual eligibles) will begin receiving their pharmacy coverage through Medicare as opposed to Medicaid. This will affect Virginia Medicaid in several ways including: (i) having to pay a portion of the cost of the program through the federal "phased-down state contribution" `requirement; (ii) facilitating the transition of dual eligibles from Medicaid to Medicare for their prescription drugs; (iii) making certain that dual eligibles receive the Part D low income subsidy; and (iv) coordinating various operational and administrative functions with Medicare, the Social Security Administration, and private prescription drug plans. Inasmuch as states were not given any additional staff or other resources from the federal government to perform these functions, Medicare Part D will have a significant impact on DMAS.

Disease State Management (DSM) Program

DMAS will be implementing a statewide DSM program on November 1, 2005, for persons enrolled in its fee-for-service program who have one of the following chronic health problems: asthma, diabetes, congestive heart failure, or coronary artery disease. The DSM program will provide patient-focused services to help these persons manage their chronic health condition, avoid more costly treatments, and remain healthy.

Managed Care Expansions

Effective September 1, 2005, DMAS will increase the number of persons enrolled in managed care when AMERIGROUP begins operations in Northern Virginia. In addition to the Northern Virginia expansion, DMAS will be increasing the number of enrollees in its managed care program through planned expansions in other parts of the state throughout 2005 and into 2006. DMAS also plans to increase the different types of enrollees participating in managed care such as those in long-term care settings.

Virginia Ranking and Trends

Virginia Medicaid historically has been one of the leanest programs in the nation. Data gathered from the National Association of State Budget Officers (NASBO) for FY 2003 showed the following:

Compared to other states, Virginia had the smallest percentage of its state population (7.3%) enrolled in Medicaid, giving Virginia the 50th rank in the nation. Comparatively, in Federal Fiscal Year 2000, Virginia ranked 47th in Medicaid recipients as a percentage of total population. Note: A first place ranking is assigned to the state with the highest percentage of its population enrolled in Medicaid.

Medicaid acute care and long-term care costs were $2.0 billion and $1.4 billion or 55.4% and 38.8% of total Medicaid expenditures, respectively. Consequently, Virginia ranked 28th and 31st in acute and long-term care spending nationwide, and 8th and 5th within the 12 southeastern states. Note: A first place ranking is assigned to the state with the highest costs.

Total Medicaid expenditures were approximately 13.4% of overall state expenditures. Virginia ranked as the 6th lowest state in the U.S. with respect to Medicaid costs as a percentage of total state expenditures. Note: A first place ranking is assigned to the state with the greatest percent of overall state expenditures devoted to Medicaid.

It must be noted that due to the wide variations among state Medicaid programs and reporting methods, there are inherent limitations with any national rankings. The above rankings must be viewed in this context.

Customer Trends and Coverage

The Department provided services to over 987,000 persons during fiscal year 2005. General population growth in Virginia and especially the growth of the aging population are key factors affecting the Department's customer base. The number of Virginians age 65 and older is projected to increase dramatically over the next ten years – over five times faster than the state's total population growth. An aging population within the state will place increased demands for services on Medicaid, especially in the areas of long-term care and waiver services.

Access to medical care for uninsured children has been a priority of the Warner administration. Since 2002, the number of children served through the FAMIS and FAMIS Plus (Medicaid for Children) programs has grown over 40% as a result of program reforms and aggressive outreach campaigns.

The enhanced ability of medical technology to treat severe illnesses and disabilities and prolong life will increase the Department's customer base.

Economic conditions also affect the number of individuals eligible for medical assistance services and other programs administered by the Department. Should there be continued economic growth in the Commonwealth, there would be a countervailing trend that would be expected to reduce the number of low-income Virginians, and, in turn, the number of individuals needing medical assistance and other services provided by DMAS.

Future Direction, Expectations, and Priorities

The future direction for DMAS will be to monitor the effectiveness and impact of recent program enhancements and initiatives, and to be proactive in the administration of the program by adjusting current activities and implementing new enhancements that improve the services we provide to our customers.

There are several factors that will impact Virginia Medicaid in the future including: (i) the aging population, especially those age 85 and older; (ii) an increase in the number of persons with disabilities seeking services; (iii) new technology requirements such as electronic health records, HIPAA (Health Insurance Portability and Accountability Act) compliance and the National Provider Identifier project; and (iv) continued growth in overall program enrollees and costs.

Perhaps the most significant issue is the current Medicaid reform efforts underway in Washington. Two of the changes that have the potential to significantly impact the operation of Medicaid in Virginia are increased cost sharing and potential benefit reductions. Regarding cost sharing, unlike the current co-payment policies, there are plans to make the new policy enforceable. This means that if a recipient does not pay, the provider will have the option to deny services. Should these proposals become law, Virginia will need to weigh the advantages of charging higher co-payments and offering limited benefit packages against the disadvantages that would likely manifest in care access problems for Medicaid recipients and greater use of emergency rooms for routine care.

Agency Priorities

The following are among the top priorities for DMAS in the future.

Expanding managed care enrollment to include new geographic areas and populations;

Increasing retention efforts to keep eligible children enrolled in Medicaid and FAMIS;

Enhancing the Department's capabilities and activities in preventing, identifying, and eliminating fraud and abuse;

Improving the effectiveness of waiver programs serving the elderly, and persons with mental retardation or other disabilities, and developing Program for All Inclusive Care for the Elderly (PACE) sites;

Monitoring the new dental program and making any needed adjustments to improve access to care; and

Improving internal processes and administrative efficiencies.

Impediments

Expenditures

Total fund expenditures for the Medicaid and FAMIS health care programs have increased from $2.753 billion in FY 2000 to $4.506 billion in FY 2005, an average annual rate of increase of 10.4 percent. This increase has occurred despite several savings initiatives that were implemented to reduce costs. As these programs continue to grow and represent an even larger share of the state budget, it will be difficult for the Commonwealth to continue to provide full funding for the program. However, without these resources, the agency will be unable to maintain the level of services offered to its customers.

Maximum Employment Level (MEL)

As the agency's programs continue to grow, there is an increased strain on DMAS' limited administrative resources, particularly its staff. The number of clients served has swelled over the past several years; however, the agency's MEL has remained relatively constant. This has placed extreme hardships on current staff that is asked to do more and more with little or no additional help. Without an increase in MEL, it will be exceedingly difficult for DMAS to meet its current service obligations, and nearly impossible to expand existing programs or add new services or activities.

Provider Reimbursement

DMAS relies on its contracted health care providers to deliver services to our customers. While there are some provider groups that often receive some level of increase in reimbursement (e.g., hospitals and nursing homes) and some that recently have received substantial increases in reimbursement (e.g., physicians providing obstetrics/gynecology services, dentists), some provider groups have received very modest increases over the past several years. Without increases in reimbursement for several provider groups, access to care will decline for our patients as providers make business decisions to no longer participate in Medicaid or FAMIS. Also, even for those providers who have received increases, they are still paid well below the amounts paid by commercial insurers. Without an annual inflation factor or other type of routine adjustment, provider reimbursement will continue to be an impediment to providing needed services to our customers.

Agency Background Information

Statutory Authority

DMAS comprises 13 specific service areas to accomplish the mission of the agency. The statutory authorities under which the service areas exist are presented below.

Involuntary Mental Commitment Fund (32107) - Code of Virginia §37.1 – 67.4

FAMIS (44602) - Federal: CFR 42 part 457; Code of Virginia §32.1-351

State Mental Health and Mental Retardation Facilities (45607) - Federal: Title XIX of the Social Security Act and CFR 42 part 440; Code of Virginia: Chapter 32.1, Chapter 10

Mental Health Mental Retardation Services (45608) - Federal: Title XIX of the Social Security Act and CFR 42 part 440; Code of Virginia: Chapter 32.1, Chapter 10

Professional & Institutional Medical Services (45609) Federal: Title XIX of the Social Security Act; Code of Virginia: Chapter 32.1, Chapter 10

Long Term Care Services (45610) - Code of Virginia: Title 32.1, Chapter 10

Indigent Health Care Trust Fund (45901) - Code of Virginia: §32.1-332 et seq.

Regular Assisted Living Program (46105) - 12 VAC 30-120-460

State and Local Hospitalization Program (46401) - Code of Virginia: Title 32.1, Chapter 12

Insurance Premium Payments for HIV-Positive Individuals (46403) - Code of Virginia: § 32.1-321.2 through 32.1-321.4, and § 63.1-124

Uninsured Medical Catastrophe Fund (46405) - Code of Virginia §32.1-324.3 and § 32.1-325

Medicaid SCHIP (46601) - Federal: CFR 42 part 457; Code of Virginia §32.1-351

Administrative & Support Services (49900) - 12 VAC 30-120-460

Customer Base:

Customer Description	Served	Potential
FAMIS	64,412	0
HIV Premium Assistance Program	78	0
Involuntary Mental Commitment Fund	8,392	0
Low-income, Aged, or Disabled Virginians	987,897	0
Medicaid (adults) and FAMIS Plus (children)	852,549	0
Medicaid Expansion Program	54,880	0
Regular Assisted Living Program	1,579	0
State/Local Hospitalization Program	6,101	0
Uninsured Medical Catastrophe Fund	6	0

Anticipated Changes In Agency Customer Base:

Medicaid Program
Approximately 87% of the DMAS customer base is served through the Medicaid program. Average monthly enrollment in this program grew 6% in FY 2003 and 9% per year in FY 2004 and FY 2005. The Department's current forecast projects 6% growth in FY 2006 and 3% growth in FY 2007, based solely on historical trends.

In addition, the number of Virginians age 65 and older is projected to increase dramatically over the next ten years, over five times faster than the state's total population growth. This growth, in turn, will increase the number of individuals receiving long-term care services and Medicare premium assistance through Virginia's Medicaid program. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established the Medicare Prescription Drug Program, known as Medicare Part D, which provides prescription drug coverage to Medicare beneficiaries. Virginians applying for Medicare Part D may find that they also qualify for Medicaid, which will increase the number of individuals served.

The increased ability of medical technology to treat severe illnesses and disabilities and prolong life will increase the Department's customer base. Statistics show that the life expectancy at age 65 has increased 12% for males and 3% for females since 1980.

Economic conditions also affect the number of individuals eligible for medical assistance services. According to the Virginia Employment Commission, the final numbers for 2004 showed strong economic growth for both the U.S. and Virginia. Continued economic growth can be expected to have somewhat of a countervailing effect on the trends noted above regarding the number of low-income Virginians needing medical assistance services.

FAMIS, FAMIS Plus (Medicaid for Children), and Medicaid Expansion
As of July 2005, over 416,000 of the estimated 432,773 uninsured children in Virginia were enrolled in one of the Department's child health insurance programs. Since 2002, the number of children served through the FAMIS and FAMIS Plus programs has grown over 40% as a result of program reforms and aggressive outreach campaigns. While this trend is expected to continue, the growth rate is expected to slow considerably as the percentage of eligible children covered under these programs nears 100%.

State and Local Hospitalization Program (SLH)
The number of recipients served through the State and Local Hospitalization Program has declined 11 percent over the past five years and this trend is likely to continue due to rising costs of medical services and the capped amount of funding available through the program.

Involuntary Mental Commitment Fund
The number of individuals placed under an involuntary mental commitment has remained relatively constant over the past five years and no significant change in this population is anticipated.

Regular Assisted Living Program
Increases in an auxiliary grant administered by the Department of Social Services will increase the eligibility for Regular Assisted Living services.

HIV Premium Assistance Program
While there has been a decline in the number of participants over the past years, it appears it is almost entirely a result of double-digit premium increases in insurance costs and not a decrease in need for the program. Additional funding provided for FY 2006 will quickly be exhausted as a large number of applications for this program has been received. A waiting list for this program will need to be reestablished within the next few months.

Uninsured Medical Catastrophe Fund
It is anticipated that the number of individuals served through the Uninsured Medical Catastrophe Fund will

increase in future years due to three key factors: 1) a newly dedicated staff position who can manage program activities, 2) current initiatives to streamline the regulations and application process, and 3) additional funding ($125,000) provided for FY 2006. However, this is a very small program and the number of persons served is limited by the available funding.

Indigent Health Care Trust Fund
No changes in this customer base are anticipated.

Agency Partners:

Advocacy groups
Advocacy groups that represent provider organizations or recipient groups on matters related to DMAS programs and services

Boards and committees
Boards and committees, established by statute or created by DMAS, serving in an advisory capacity in an area of subject matter expertise and/or providing assistance in the formulation of program policy

Federal agencies
Federal agencies that provide funding and oversight for the Medicaid and Title XXI programs as well as the Medicare program

Health care professionals, organizations, and facilities
Health care professionals, organizations, and facilities rendering medical services to clients of Medicaid, FAMIS, or other indigent health care programs administered by DMAS

Private business firms
Private business firms, contracted by DMAS, providing program functions including claims processing, recipient enrollment, prior authorization of medical services, brokered transportation services, cost settlement and audit reviews, managed care enrollment, and actuarial services

State and local entities
State and local entities providing medical services covered and reimbursed by Medicaid or FAMIS programs or performing various program functions (e.g., recipient enrollment)

State government officials
State government officials in both the executive and legislative branches of government who are responsible for setting agency priorities, determining health care policy, assisting DMAS deliver its services, setting DMAS' appropriation levels and enacting legislation

Agency Products and Services:

Current Products and Services

DMAS has five broad classifications of services. Long Term Care, Special Programs and FAMIS, are provided directly to external clients, the recipients. Administration helps DMAS to better serve its clients through a network of internal agency support services. Operations has three different types of services: direct services for clients, intermediary services for our partners to aid them in providing quality service to our clients, and program management services to preserve the integrity of the system for all the citizens of Virginia.

Long Term Care (LTC) and Waiver Programs
DMAS provides long term care services including coverage for nursing home care, and the development and management of waiver programs (e.g., home and community based waivers, and mental retardation waivers) that target access for health care to special populations.

Special Programs Not Covered by Medicaid
DMAS is responsible for several programs that have different funding and administration streams than Medicaid. These programs include a health insurance premium payment program, an indigent trust fund, an uninsured catastrophe fund, and a state and local hospitalization program.

FAMIS – Family Access to Medical Insurance Security
FAMIS is the state's health insurance program that covers traditional health care services to uninsured children in families with incomes that exceed Medicaid levels. This program has a federal match that is separate from the Medicaid program and also has a separate state plan. Along with the provision of medical services, the program includes outreach, eligibility determination, enrollment, and policy development.

Administration – Several administrative services support management and staff in carrying out the mission of the organization: human resources, procurement, strategic planning, workforce development, training, contract development and management, and property management.

Operations

Health care services – DMAS provides traditional health insurance products and programs for hospital stays, outpatient services, pharmacy, labs/x-rays, mental health, dental, vision, ancillary services, equipment and supplies. DMAS also provides transportation services for Medicaid recipients.

Enrollment and member services – These services include recipient call centers, mailings to recipients, membership enrollment, and a process for recipient appeals.

Provider enrollment, services and reimbursement – These services include claims processing and reimbursement, education and training, medical support and consultation, provider call centers, mailings to providers, prior authorizations, provider and customer service, provider enrollment, network analysis, and provider appeals.

Program integrity – Functions include a) provider and recipient audits, b) compliance, fraud and utilization reviews, c) internal audits and reviews, and d) reengineering and process improvement.

Financial service – In order to manage a multi-billion dollar program, the department has established several financial functions including accounting, budget development, forecasting, rate development, financial analysis, fund management, fiscal operations, and reporting. The department also contracts with an actuarial firm.

Policy analysis and information dissemination – DMAS provides policy analysis and development; development and promulgation of state and federal regulations, state plans and waivers; evaluation of programs; development of studies, position papers, surveys and research; quality reviews; grants development; legislative tracking and development; constituent communication; briefings to the Governor, Secretary Health and Human Resources and Legislature; website administration; media requests and interviews; and freedom of information requests.

Factors Impacting Agency Products and Services

The scope of the products and services provided by DMAS continues to be effected by changes taking place in the health care sector in general. These changes include, new health care technologies, the continued emphasis on treating individuals in an outpatient setting or in the community as opposed to treating individuals in the facilities, and the increasing use of care management programs to manage and improve health outcomes especially for individuals with specific conditions.

The largest factor impacting the provision of administrative services and operations is the use of technology enhancements to increase the efficiency of the programs, expedite the services that are provided by the agency and increase the access to information needed to perform policy analysis and program integrity.

Anticipated Changes in Agency Products and Services

It is expected that the provision of Long Term Care (LTC) and Waiver Programs services will continue to increase. In recent years numerous new waiver programs have been proposed which target individuals based on a specific condition/diagnosis. In addition, as the number of citizens in the Commonwealth over the age of 65 increases there will be increased demand for community based care services.

For primary health care services DMAS expects to continue to increase the number of customers who receive their health care through private managed care organizations as opposed to the Medicaid fee-for-service system.

DMAS continues to emphasize technology improvements, both through DMAS' internal operations and through companies contracted with DMAS' to provide support services to improve services provided under DMAS' operations. Specific improvements which have occurred recently or will occur in the near future are in the operation of the provider call center, the membership enrollment processes and the prior authorization process.

Agency Financial Resources Summary:

DMAS' budget is currently funded with approximately 43.0% state general funds, 50.4% federal funds and 6.6% special funds. The largest source of special funds is the Virginia Health Care Fund.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$2,152,985,491	$2,853,046,659	$2,152,985,491	$2,853,046,659
Changes To Base	$217,290,325	$52,262,146	$385,696,163	$235,189,423
AGENCY TOTAL	**$2,370,275,816**	**$2,905,308,805**	**$2,538,681,654**	**$3,088,236,082**

Agency Human Resources Summary:

Human Resources Overview

The Department of Medical Assistance Services is a highly professional organization with 331 authorized classified positions. As of July 1, 2005, 312 of these positions are filled and 19 are vacant. Five of the classified employees are located in the Roanoke Office and one is located in Manassas. Because of

increasing program requirements, the Department has had to use increasing numbers of hourly employees. Most of the contract employees work in the Information Management Division and played a critical role in the development of the Virginia Medicaid Management Information System. The Department has 15 divisions/offices, which include the Office of the Director. Forty-three role titles are used and the most prevalent are the Health Care Compliance Specialist II (29%), Health Care Compliance Specialist I (22%), Administrative and Office Specialist III (19%), and Program Administration Specialist II (18%).

Full-Time Equivalent (FTE) Position Summary

Effective Date:	7/1/2005
Total Authorized Position level	331
Vacant Positions	-19
Non-Classified (Filled)	2
Full-Time Classified (Filled)	310
Part-Time Classified (Filled)	0
Faculty (Filled)	0
Wage	79
Contract Employees	31
Total Human Resource Level	**422**

Factors Impacting Human Resources

Increased programmatic requirements continue to necessitate the extensive hiring of hourly employees. The hourly employees serve a vital role and require the same level of training as full-time employees. However, most of these employees seek other employment with benefits. Thus, the turnover rate among the hourly workforce for the past fiscal year was 33.3%. The restriction of 1500 work hours per year for hourly workers also has a negative impact on productivity.

There is some concern regarding the aging workforce. The average age of the Department classified workforce is 47 years. As of July 1, 2005, fifteen employees are eligible for full retirement being age 50 with 30 years of service. Ninety-two employees (30%) are age 50 with 10 years of service and could retire with partial benefits, although most employees prefer to retire with full benefits. During the next five years, 15 employees will be eligible for full retirement, six of whom are high level managers or division directors. These figures do not include employees who have purchased prior service and may be eligible for retirement much sooner.

The turnover rate for classified employees leaving the Department during the past fiscal year was 11.5 percent. Most of these employees left the Department for advancement reasons. Of this number, only 5% left state government compared to the statewide percentage of 10.4%. The remaining employees either retired (4) or transferred to another state agency.

Anticipated Changes in Human Resources

Due to budget constraints, employee training has received little emphasis in past years. However, an hourly employee recently was hired to coordinate employee training. As a result, the Department is increasing the amount of employee training opportunities. DMAS recently completed a series of classes on customer service and computer software training that was well received. This type of training will be offered in the future if funding is available.

We anticipate greater use of the Learning Management System both internally and with the programs offered by the Department of Human Resource Management. The Learning Management System is a

Web-based system designed to present learning and knowledge sharing opportunities to its users. It promotes learning through online course offerings, classroom course registration, and a consolidated transcript of all learning events for individual users. The system DMAS has purchased is the Meridian KSI Knowledge Center (TM). There will be some cost attached to these programs

It is anticipated that there will be improvement in automated databases provided by the Department of Human Resource Management and the Department of Accounts.

It is hoped that the Maximum Employment Level will be raised so that the dependence on hourly employees can be considerably reduced and focused on short-term emergency needs.

Even though the turnover rate is not as high in the Department as in some other agencies, retention of highly skilled employees must be emphasized through effective employee recognition programs and fair and consistent compensation practices.

Agency Information Technology Summary:

Current State / Issues

The current period of the Medicaid Management Information System (MMIS) fiscal agent contract will end on June 30, 2008. There are two remaining option years allowed under the contract. DMAS must evaluate whether the option years should be exercised or whether it is in the best interest of the Agency and Commonwealth to take steps to re-bid the MMIS contract without exercising the remaining option years.

The Third Party Liability System Recovery System (TPLRS) is running on a hardware platform that is aging and will exceed lifetime expectancy guidelines in this period.

The Program Operations Division has identified customer service improvements that they would like to initiate that will require Information Technology support.

DMAS operates a mission-critical function using the Oracle Government Financials system. The Agency needs to support the system through required maintenance and enhancements as well as any product upgrades.

The network infrastructure, servers, desktop workstations, and applications that are used by DMAS staff must be maintained and kept current. This makes up the Information Retrieval Platform (IRP) at DMAS, which is a component of the MMIS.

Factor Impacting Information Technology

HIPAA Transactions, Code Sets and Identifiers Rules require ongoing compliance to standardization of electronic data interchange (EDI). The following actions relate to this issue.

The National Provider ID (NPI) is mandated to become the primary identifier for health care individuals and organizational entities. Electronic standard transactions will be impacted by the change to this identifier for identifying servicing and billing provider entities.

Electronic Claim Attachments will be mandated to replace the supplemental media (paper, X-rays, faxes, etc.) used today for claim payment justification and prior authorization referrals.

The Center for Medicare and Medicaid Services (CMS) is looking at using an X12 Transaction (274) for ongoing dissemination of NPI information from the National Plan and Provider Enumeration System (NPPES) in response to plans request for verification of data. This would impact the provider enrollment process.

Anticipated Changes / Desired State

The Information Management Division will continue to coordinate regular reviews of the performance of the MMIS fiscal agent contractor (First Health Services Corporation) and evaluate the results to make a recommendation regarding the advantages and disadvantages of exercising either the first or both of the remaining option years.

DMAS must evaluate whether the option years of the Fiscal Agency contract should be exercised or whether it is in the best interest of the Agency and Commonwealth to take steps to re-bid the MMIS contract without exercising the remaining option years. As part of due diligence effort, DMAS is anticipating the use of functional consultants to assist in a competitive procurement, which could include the functional and business resources for planning, transitioning, testing, implementation and validation activities that would be part of a new Fiscal Agent contract.

The hardware platform used to run the Third Party Liability Recovery System (TPLRS) will be replaced with a more state-of-the-art system to increase maintainability and efficiency and reduce risk of hardware failure.

The Information Management Division will work with the Program Operations Division to identify web-based applications that can be developed to improve customer services for MMIS providers. Anticipated improvements include features such as direct data entry of claims, accessing remittance advices on the Web, interactive on-line documentation, and broadcast e-mail capabilities.

The Information Management Division will maintain and enhance the Oracle Government Financials system to support the requirements of the Agency and Commonwealth. Vendor upgrades to the software application will also be monitored and upgrades will be evaluated, scheduled, and performed as needed.

The Information Management Division will continue to maintain the network infrastructure, servers, desktop hardware and software used by DMAS staff. Upgrades to IT resources will be evaluated, recommended, procured, and applied as needed to meet DMAS' mission and changing technology.

Anticipated Changes / Desired State

The short-term solution for NPI will be to change the databases and EDI extractions to use either NPI or Legacy identifiers in the Medicaid Management Information Systems during a transition period leading up to the mandatory compliance date. MMIS program logic will be modified.

The long-term solution for NPI will be to change the relationship structure of the databases to use the NPI as the primary identifier that is linked with the variables related to the NPI in one record versus multiple records today. MMIS software logic will be modified to use the new identifiers.

The systems will link claims or prior authorization requests with electronic images received from Trading Partners. There will be viewing capability of electronic images at the desktop level, for review of claims or prior authorization attachments for verification and approval.

A process of accessing provider credentials and information from the CMS NPPES will be integrated into the DMAS Provider Enrollment Process for cross validation of NPI data and provider credentialing.

Development and use of data for an Electronic Health Record will be done. Exchanges of information for state and/or federal data sharing would need to be accommodated. In addition, a decision support system would require secure access as well as possible data update capability.

Agency Information Technology Investments:

	Cost-Fiscal Year 2007		Cost-Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Major IT Projects	$0	$0	$0	$0
Non-Major IT Projects	$0	$0	$0	$0
Major IT Procurements	$2,834,560	$10,641,756	$3,882,625	$12,837,567
Non-Major IT Procurements	$1,115,378	$2,619,183	$1,506,251	$3,102,037
Totals	**$3,949,938**	**$13,260,939**	**$5,388,876**	**$15,939,604**

Agency Goals

Goal #1:

Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

Goal Summary and Alignment:

The mission of the Department of Medical Assistance Services (DMAS) is to provide eligible individuals with access to needed health care. DMAS plays an important role in providing this access and in influencing policies that extend access to those most in need.

This goal supports the Council on Virginia's Future Long-Term Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #2:

Promote better health outcomes through prevention-based strategies and improved quality of care.

Goal Summary and Alignment:

Although DMAS does not directly provide health care services, it does have a role in ensuring that those who are eligible for its services receive quality health care. DMAS believes that a focus on prevention-based strategies will reap positive health benefits for its clients and sound fiscal benefits for taxpayers.

This goal supports the Council on Virginia's Future Long-Term Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #3:

Enhance the delivery of health care services by improving communication and relationships with customers and partners.

Goal Summary and Alignment:

Effective communication is vital to ensure that DMAS' partners understand the administrative/legal aspects of DMAS services, as well as the outcomes DMAS is striving to achieve on behalf of its clients. Equally important is the dissemination of information to eligible and enrolled individuals who ultimately benefit from these important services.

This goal supports the Council on Virginia's Future Long-Term Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #4:

Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.

Goal Summary and Alignment:

A good work environment helps to create satisfied employees who, in turn, create satisfied customers and partners. DMAS strives to provide the best possible work environment for its staff members by recognizing accomplishments, expanding the knowledge base of staff members and maintaining open lines of communication to ensure the workforce has the information it needs to effectively accomplish the organization's goals.

This goal supports the Council on Virginia's Future Long-Term Objective #1: To be recognized as the best managed state in the nation.

Goal #5:

Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

Goal Summary and Alignment:

DMAS is responsible for managing a multi-billion dollar enterprise. Sound fiscal management and strict compliance with accepted financial standards and controls is essential for protecting these resources. DMAS will continue to rigorously examine the way it operates to reduce waste and to prevent fraud and abuse.

This goal supports the Council on Virginia's Future Long-Term Objective #1: To be recognized as the best managed state in the nation

Goal #6:

Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

Goal Summary and Alignment:

A hallmark of any well-managed organization is its desire to continually examine the way it works in order to find ways to improve effectiveness and efficiency. To accomplish this, DMAS will search for best practices within and outside of the health care industry and state government and will strive to develop innovative approaches for delivering services to its clients.

This goal supports the Council on Virginia's Future Long-Term Objective #1: To be recognized as the best managed state in the nation.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Medical Services Related to Involuntary Mental Commitments (32107)

Service Area Background Information

Service Area Description

An Involuntary Mental Commitment, also known as a Temporary Detention Order (TDO), is the detainment of an individual who i) has been determined to be mentally ill and in need of hospitalization, ii) presents an imminent danger to self or others as result of the mental illness or is so seriously mentally ill as to be substantially unable to care for self, and iii) is incapable of volunteering or unwilling to volunteer for treatment. A magistrate issues the TDO. The duration of the order shall not exceed 48 hours prior to a commitment hearing. If the 48-hour period terminates on a Saturday, Sunday or legal holiday, such person may be detained until the next business day.

DMAS determines the allowable eligibility period for the client who is under an involuntary mental commitment and enrolls the client in the involuntary mental commitment program. DMAS ensures that all other available payment resources have been exhausted prior to payment by this program, which is funded only through state funds. Once this is completed, DMAS processes and adjudicates claims for the allowable services provided to clients under an involuntary mental commitment.

Service Area Alignment to Mission

This service area is in line with DMAS' mission to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians. By ensuring that appropriate services are provided to eligible persons, DMAS provides access to needed care for this population of clients.

Service Area Statutory Authority

Code of Virginia §37.1 – 67.4: This section provides the process for an individual who is in danger of harming himself/herself or others to have a mental health evaluation to determine the correct plan of action and treatment. Should this evaluation result in the issuance of an involuntary detention order, the timeframe for the detainment is outlined and the payer of the services provided during the detention is identified.

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	8,392	0

Anticipated Changes In Service Area Customer Base

The number of clients placed under an involuntary mental commitment has remained relatively constant over the past five years and no significant change in this population is anticipated at this time.

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Medical Services Related to Involuntary Mental Commitments (32107)

Service Area Products and Services

- Operations (Enrollment & Member Services) – Determination of the involuntary mental commitment eligibility and enrollment for providers and clients
- Operations (Provider Enrollment, Services and Reimbursement) – Determination of the per diem rate of reimbursement for all services provided
- Operations (Health Care Services) – Coverage for involuntary mental commitment services

Factors Impacting Service Area Products and Services

Provider knowledge of the involuntary commitment process and the timely filing of claims for their services impacts whether these services are used.

In addition, DMAS has received ongoing concerns regarding the lack of providers willing to accept and treat TDO clients within their facilities. DMAS' responsibility for this program does not encompass the process of placing TDOs within facilities; however, the lack of access for these services does impact the amount of expenditures incurred for this program.

Anticipated Changes To Service Area Products and Services

No changes are anticipated, unless there is legislative action that would increase or decrease the services.

Service Area Financial Summary

The Involuntary Mental Commitment program is funded 100% with state General Fund.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$11,180,391	$0	$11,180,391	$0
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$11,180,391**	**$0**	**$11,180,391**	**$0**

Service Area Objectives, Measures, and Strategies

Objective 32107.01

Ensure that providers that are treating TDO clients continue to be compensated for the allowable services they provide and ensure that these services are within the timeframe of the commitment order

Provide reimbursement for the services provided to the client who is detained under the involuntary mental commitment.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 32107.01.01**

  Percentage of accurate reimbursement payments processed in time standard

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: To be determined from reports gathered October 1 through December 31, 2005

  Measure Target: For FY 2007, 90% of all clean claims will be adjudicated within 30 calendar days of receipt at DMAS.

  Measure Source and Calculation:

  VaMMIS reports and a manual staff log will be used to capture the date a clean claim was received at DMAS, First Health Julian processing date, date adjudicated for payment, actual remittance advice date, number of accurate compared to total reimbursement payments, and the proportion of services provided within commitment order timeframes

Objective 32107.01 Has the Following Strategies:

- Revise and update TDO billing instructions.
- Provide training for providers on the TDO process and responsibility.
- Revise the inpatient activity and outpatient activity, professional and locality court reports to include yea-to-date information as well as the recent month data that is currently shown.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan (44602)

Service Area Background Information

Service Area Description

The Family Access to Medical Insurance Security (FAMIS) program is part of Virginia's Title XXI program for uninsured children and pregnant women living below 200% and 150% of the federal poverty level (FPL) respectively. The FAMIS program provides access to comprehensive health care services for qualifying children through a benefit plan modeled on the state-employee health plan in areas where a contracted managed care organization is available; and through a Medicaid look-alike benefit plan in fee-for-service areas. FAMIS requires family cost sharing through co-payments for services and provides a premium assistance option for private/employer-sponsored insurance.

Service Area Alignment to Mission

FAMIS carries out the mission of DMAS by providing access to a comprehensive system of high quality and cost effective health care services to uninsured children whose families earn too much to qualify for Medicaid but too little to afford private health insurance

Service Area Statutory Authority

Statutory Authority
CFR: 42 part 457
§32.1-351 Code of Virginia

Service Area Customer Base

Customer(s)	Served	Potential
Uninsured children under 19 with family income >133% FPL (federal poverty level) and < 200% FPL	64,312	0
Uninsured pregnant women with income > 133% FPL and < 150% FPL.	0	700

Anticipated Changes In Service Area Customer Base

The customer base of children eligible for the FAMIS program is likely to remain approximately the same for the next several years. Factors that could affect the number of customers would include a downturn in the Virginia economy, private insurance market forces that result in an increase in rates of uninsurance, a significant increase in the under 19 population, or policy changes affecting program eligibility.

The customer base for the new FAMIS MOMS program for pregnant women is likely to grow in the next few years as the program matures. Similar to FAMIS, economic and population demographics will also impact the customer base for FAMIS MOMS.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- FAMIS & FAMIS MOMS
  Coverage for comprehensive health care services through managed care or fee-for-service
  Marketing and outreach to promote enrollment
  Application processing and enrollment
  Claims payment

Factors Impacting Service Area Products and Services

Federal and state appropriations and regulations impact the nature and scope of the services than can be provided through FAMIS. Unlike Medicaid, FAMIS is not an entitlement program

Anticipated Changes To Service Area Products and Services

Congress must reauthorize Title XXI no later than 2007. It is likely the federal funding formula that determines Virginia's annual allotment will be revised.

FAMIS will be expanded to include coverage of uninsured pregnant women with income greater than 133% FPL but less than or equal to 150% FPL as of August 1, 2005. Women enrolled in FAMIS MOMS will receive Medicaid-like benefits for the duration of their pregnancies and for two months postpartum.

Service Area Financial Summary

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$17,288,065	$68,361,011	$17,288,065	$68,361,011
Changes To Base	($1,413,253)	$1,612,182	$2,102,892	$8,142,165
SERVICE AREA TOTAL	**$15,874,812**	**$69,973,193**	**$19,390,957**	**$76,503,176**

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan (44602)

Service Area Objectives, Measures, and Strategies

Objective 44602.01

Enroll all eligible children in the FAMIS program

While enrollment of eligible children in the FAMIS program has increased dramatically, there are still thousands of uninsured children who could be covered and additional children who become uninsured every day. It is in the best interest of the children, their families and the Commonwealth to provide comprehensive health care coverage through the FAMIS program to this vulnerable population.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services.)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 44602.01.01**

  The percentage of eligible children enrolled in FAMIS or FAMIS Plus

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: As of July 1, 2005, approximately 416,548 or 96% of estimated eligible children are enrolled in either FAMIS or FAMIS Plus. Updated calculation input will likely revise this baseline estimate downwards.

  Measure Target: The enrollment target for the FAMIS program will remain at 95% or better for FY 2006. This target has been set in anticipation of revisions to the eligible population's estimated size.

  Measure Source and Calculation:

  Data Source: Data from VAMMIS on the number of children enrolled in FAMIS on the first day of each month, following all cancellations that occur on the last day of each month, will be reported. This number will be combined with enrollment data for FAMIS Plus (Medicaid) and compared to the number of children estimated to be eligible for publicly supported health insurance in Virginia for a percentage of overall enrollments.

  Calculation:
  Estimates of eligible children are calculated by a formula based on Census data, poverty rates by locality and results of the 2001 Health Access Survey conducted by the Virginia Health Care Foundation. This formula is evaluated periodically as current data become available.

Objective 44602.01 Has the Following Strategies:

- Develop and implement a general marketing campaign specifically designed to retain current children and reach families with FAMIS eligible children.
- Develop outreach activities and materials to reach traditionally "hard-to-reach" populations.
- Increase the use of technology to improve customer service for interested families and to facilitate application processing and enrollment.

Objective 44602.02

Increase utilization of appropriate preventive care by FAMIS enrolled children

Over 64,000 children have been served through the FAMIS program in FY 2005. This objective will focus DMAS' efforts to improve health outcomes for children and reduce long-term health care costs by improving the timely and appropriate utilization of preventive health care services.

This Objective Supports the Following Agency Goals:

- Promote better health outcomes through prevention-based strategies and improved quality of care.

  (Promote better health outcomes through prevention-based strategies and improved quality of care. Council on Virginia's Future Objective)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 44602.02.01**

  Childhood immunization rate

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: Childhood immunizations (full immunization series at 24 months) for FY 2004 = 84% compliance

  Measure Target: Childhood immunizations (full immunization series at 24 months) for FY 2006 = 86%

  Measure Source and Calculation:

  DMAS contracts with an external quality review organization to study the rate of appropriate immunizations for children covered by FAMIS and FAMIS PLUS. The number of children receiving the recommended immunizations by age group is divided by the number of children covered by the programs. Health Plan Employer Data and Information Set (HEDIS) data from contracted managed care organizations and claims data are analyzed.

- **Measure 44602.02.02**

  Well-child visit rate

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: Well-child visits for FY 2004 = 57% of 15-month-old children received the recommended number of visits and 54% of 3 to 6 year old children received the recommended number of visits

  Measure Target: Well-child visits – Compliance with recommended number of visits for 15-month-old children in CY 2008 = 70%; compliance with recommended number of visits for 3 to 6 year old children in CY 2008 = 70%

  Measure Source and Calculation:

  DMAS contracts with Delmarva Foundation to study utilization of appropriate well child visits by the FAMIS population. Both administrative claims data from VAMMIS and medical record data are reviewed. The rate of 15-month-old children receiving the recommended number of well-child visits is determined by comparing the number of children in this age group who received six or more well-child visits since birth to the total number of 15-month-old children enrolled. The rate of 3 to 6 year old children receiving recommended well-child visits is determined by comparing the number of children in this age group receiving one or more well-child visits during the study period to the total number of 3 to 6 year old children.

- **Measure 44602.02.03**

  Routine dental care utilization percentage

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: Routine dental care – FFY 2003, approximately 466,705 Medicaid enrollees over the age of three and under the age of 21 were eligible for services and the % of Medicaid/FAMIS children receiving care was approximately 22%.

  Measure Target: Routine dental care – Utilization percentage at or beyond 40% for FY 2007

  Measure Source and Calculation:

  DMAS claims data are utilized to determine the number of children covered by FAMIS or FAMIS PLUS between the age of three and twenty-one receiving routine dental care visits. This number is divided by the number of children in this age group enrolled in the program.

Objective 44602.02 Has the Following Strategies:

- Continue to promote appropriate childhood immunizations for the FAMIS population.
- Promote utilization of well child check-ups covered by the FAMIS plan and remind providers of the importance of regular checkups, immunizations, and the coordination of information among providers.
- Promote utilization of preventive pediatric dental visits by the FAMIS population.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements to State-Owned Mental Health and Mental Retardation Facilities (45607)

Service Area Background Information

Service Area Description

The service area reimburses facilities owned and operated by the Department of Mental Health and Mental Retardation and Substance Abuse Services (DMHMRSAS) for medically necessary services provided to Medicaid eligible recipients residing in these facilities.

The DMHMRSAS operates 15 state mental health or mental retardation facilities, that provide highly structured intensive inpatient treatment and habilitation services. The state mental health facilities provide a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. The mental retardation training centers provide residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development. The Hiram Davis Medical Center provides medical care to state facility patients and residents.

DMAS works in partnership with the DMHMRSAS to ensure that services are medically necessary, provided in the most appropriate setting and that the reimbursement rates are sufficient to help maintain the financial viability of these state owned facilities.

Service Area Alignment to Mission

By providing coverage for the services provided through the Commonwealth's public MHMR facilities we are ensuring access to needed medical care for a vulnerable population.

Service Area Statutory Authority

Federal Legislation: Title XIX of the Social Security Act
CFR: 42 part 440
Code of Virginia: Chapter 32.1, Chapter 10

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients: Low-income, Aged, and Disabled Virginians with Mental Health/Mental Retardation Diagnoses	3,218	0

Anticipated Changes In Service Area Customer Base

The average daily census at Virginia's state mental health facilities and state mental retardation training centers has declined steadily over the past 30 years due to various facility discharge and diversion projects and the increased use of atypical antipsychotic medications. This trend is evident in the Medicaid-funded utilization, which has declined 61 percent at state mental health facilities and 16 percent at state mental retardation training centers over the past ten years. However, in fiscal year 2004, the Virginia Medicaid program covered treatment services for 1,504 residents of state mental health facilities and 1,714 residents of state mental retardation training centers. This represents a nine percent growth over the 2,957 individuals served in fiscal year 2003. Despite efforts to care for persons in the community, the increase in the number of Medicaid recipients served is expected to continue as a result of shorter lengths of stay and higher turnover coupled with the increasing improving ability to assess mental retardation and co-occurring mental or physical disabilities, such as including mental illness, and autism. and shorter lengths of stay, which lead to higher turnover.

Service Area Partners

Advocacy groups

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Health Care Services) – Coverage of Mental Health and Mental Retardation Health Care Services
- Operations (Financial Services) – Rate Setting/Cost Analysis
- Operations (Provider Enrollment, Services and Reimbursement) – Claims Payments; Prior Authorization

Factors Impacting Service Area Products and Services

Federal regulations limit the types of individuals who are eligible to receive Medicaid coverage in Institutions for Mental Disease (IMD). The Code of Federal Regulations (CFR) prohibits covering individuals between age 22 through age 64 while residing in an IMD. This does not apply to individuals diagnosed with Mental Retardation.

Total reimbursement to the facilities is limited by State appropriations

Anticipated Changes To Service Area Products and Services

It is anticipated that services will decrease in accord with the trend of a declining population.

Service Area Financial Summary

Funding for the services is covered through the Medicaid program.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$107,991,696	$114,628,651	$107,991,696	$114,628,651
Changes To Base	($2,785,331)	($9,422,286)	($6,427,206)	($13,064,161)
SERVICE AREA TOTAL	**$105,206,365**	**$105,206,365**	**$101,564,490**	**$101,564,490**

Service Area Objectives, Measures, and Strategies

Objective 45607.01

To ensure an appropriate level of care is provided to Medicaid eligible individuals in the DMHMRSAS facilities

It is DMAS' responsibility to ensure Medicaid payments are made for medically necessary and appropriate care.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services.)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45607.01.01**

  Percentage of payments to DMHMRSAS facilities for persons who have been pre-approved for services

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: To be determined

  Measure Target: 100% of claims are paid for individuals who have been appropriately authorized for services

  Measure Source and Calculation:

  Data Source: Agency's Medicaid Management Information Systems (VaMMIS)Calculation: The number of individuals for whom DMAS made payments who were screened for medical necessity and pre-approved divided by the total number of recipients

Objective 45607.01 Has the Following Strategies:

- Ensure that prior authorization for admittance to these facilities is done in accordance with the Medicaid policy as stated in the Medicaid manuals.
- DMAS shall perform periodic utilization reviews of services provided to recipients within the facilities.

Objective 45607.02

To reimburse the DMHMRSAS facilities in a timely and accurate manner

A significant portion of the patients served in these facilities are Medicaid eligible, therefore the prompt and accurate payment is necessary to ensure their financial viability.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services.)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45607.02.02**

  Percentage of valid and complete claims that are processed within the DMAS time standard

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: To be determined

  Measure Target: 100% of valid and complete claims are processed within 30 calendar days of receipt of the claim

  Measure Source and Calculation:

  Data Source: Agency's data system – Medicaid Management Information System (VaMMIS)

  Calculation:
  The number of valid claims processed within 30 calendar days of receipt divided by the total number of valid claims received.

Objective 45607.02 Has the Following Strategies:

- Educate and train providers on the proper submission of complete and valid claims.
- Work with providers so that electronic billing systems are developed in a manner consistent with HIPAA standards and can effectively interface with VaMMIS.

Service Area Background Information

Service Area Description

This service area reimburses providers, both public and private, for the treatment of mental illness, including long-term serious mental illness and short-term acute problems and for mental retardation case management services. Other mental retardation based services are provided in the long term care service area. Medicaid covers outpatient services, inpatient services under certain circumstances, and community-based mental health rehabilitative services to individuals who meet specified criteria for each service.

DMAS, in partnership with the DMHMRSAS, the Community Services Boards and community providers and advocates, continues to work to ensure access to needed MHMR services in the most appropriate setting.

Service Area Alignment to Mission

By providing coverage for these mental health and mental retardation case management services we are ensuring needed medical care for a vulnerable population

Service Area Statutory Authority

Federal Legislation: Title XIX of the Social Security Act
CFR: 42, Part 440
Code of Virginia: Chapter 32.1, Chapter 10

Service Area Customer Base

Customer(s)	Served	Potential
Clients / Beneficiaries: Low-income, Aged, and Disabled Virginians with a MH/MR diagnosis	45,348	0

Anticipated Changes In Service Area Customer Base

In fiscal year 2004, the Virginia Medicaid program covered fee-for-service inpatient treatment services for 580 residents in private mental health facilities and fee-for-service outpatient mental health services for 44,768 individuals. This represents an eight percent growth over the number of individuals served in fiscal year 2003. This growth is due to several factors including overall growth in enrollment in the Virginia Medicaid program and a trend towards community-based, rather than institutional treatment settings. These factors are likely to lead to continued growth in the number of individuals receiving Medicaid-covered mental health services.

In addition, as the population ages, the Medicaid program is likely to see an increasing number of individuals with mental illness who will require community-based services to enable them to reside in a nursing home or assisted living facility.

The Virginia Medicaid program covers services provided by both state-owned and private community mental health and mental retardation facilities. In FY 2004 a total of 2,084 individuals received fee-for-service inpatient mental health services and 1,995 individuals received fee-for-service inpatient mental retardation services. The numbers above refer only to those recipients served in state-owned facilities. The recipients served in private community facilities are included in other Service Area Plans. These figures do not include the number of individuals who receive mental health or mental retardation services provided through a Medicaid capitated managed care plan.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials
Federal agencies
State and local entities
Private business firms
Health care professionals, organizations, and facilities
State government officials

Factors Impacting Service Area Products and Services

Federal regulations, Virginia's State Plan and the Code of Virginia all address mental health services covered by Medicaid.

In recent years there has been a significant increase in the number of mental health providers enrolled to participate in the Medicaid program.. This has increased access to the services and increased utilization.

Anticipated Changes To Service Area Products and Services

Current trends toward new model of community-based care increase utilization of these services. In addition, current efforts are aimed at increasing flexibility to improve access.

Service Area Financial Summary

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$246,641,311	$246,641,311	$246,641,311	$246,641,311
Changes To Base	($92,157,698)	($92,157,697)	($81,618,077)	($81,618,076)
SERVICE AREA TOTAL	**$154,483,613**	**$154,483,614**	**$165,023,234**	**$165,023,235**

Service Area Objectives, Measures, and Strategies

Objective 45608.01

Increase access to outpatient and community-based mental health services

Outpatient and community-based mental health services have proven to be a cost-effective alternative to inpatient placement and improve the quality of life for individuals in need of mental health treatment.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services.)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families)

This Objective Has The Following Measure(s):

- **Measure 45608.01.01**

  Outpatient/inpatient utilization ratio

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: In FY 2005, the ratio of individuals utilizing outpatient and community-based mental health services compared to inpatient utilization was 27 to 1.

  Measure Target: For FY 2007, increase the ratio to 30 to 1.

  Measure Source and Calculation:

  Divide the number of individuals receiving outpatient mental health services by the number of individuals receiving inpatient mental health services as recorded in the MMIS

Objective 45608.01 Has the Following Strategies:

- Continue to work with DMHMRSAS, the Community Service Boards, and community advocates and providers to identify barriers to access and implement changes to the extent allowed by federal and state regulations.

Service Area Background Information

Service Area Description

This service area represents the largest single component of the Department's programs and activities, the Title XIX Medicaid program. The primary functions that the department performs in this area are: i) working with local departments of social services to enroll persons into the appropriate categories of eligibility; ii) providing support services to enrollees; iii) developing and maintaining provider networks and ensuring access to needed health services; iv) reimbursing providers for necessary and appropriate health care services; iv) ensuring the program operates efficiently; and v) developing new program features to improve the quality of care and control costs.

Service Area Alignment to Mission

By performing the functions within this service area, we are able to provide access to a comprehensive system of high quality and cost effective health care services to our customers.

Service Area Statutory Authority

Title XIX of the United States Code and Chapter 10 of Title 32.1 of the Code of Virginia

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients*	852,549	0

Anticipated Changes In Service Area Customer Base

Approximately 87% of the department's customer base is served through the Medicaid program. Average monthly enrollment in this program grew 6% in fiscal year 2003 and 9% each year in fiscal years 2004 and 2005. The department's current forecast projects 6% growth in fiscal year 2006 and 3% growth in fiscal year 2007, based solely on historical trends.

In addition to average annual growth, the number of Virginians age 65 and older is projected to increase dramatically over the next ten years – over five times faster than the state's total population growth. This growth in turn will increase the number of individuals receiving Medicare premium assistance and long-term care services through Virginia's Medicaid program.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Program, also known as Medicare Part D, which provides prescription drug coverage to Medicare beneficiaries. Virginians applying for Medicare Part D may find that they also qualify for Medicaid, which will increase the number of individuals served.

The increased ability of medical technology to prolong life will increase the department's customer base. Statistics show that the life expectancy at age 65 has increased 12% for males and 3% for females since 1980.

Outreach efforts to enroll additional children in FAMIS or Medicaid also will increase the customer base.

Economic conditions also affect the numbers of individuals eligible for medical assistance services. According to the Virginia Employment Commission, the final numbers for 2004 showed strong economic growth for both the U.S. and Virginia. Continued economic growth can be expected to produce a countervailing trend that may suppress the number of low-income Virginians and in turn the numbers of individuals needing medical assistance services.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Enrollment and Member Services)
- Operations (Provider Enrollment, Services, and Reimbursement) – Special provider Reimbursement Projects (E.G., Revenue Maximization, Teaching Hospital DSH)
- Operations (Program integrity) – Quality Assurance
- Operations (Healthcare Services) – Operational support; New Program Development (e.g., ED 2, DSM, Dental)

Factors Impacting Service Area Products and Services

The following factors will impact the services provided within this service area:
The Governor's emphasis on enrolling additional children in Medicaid;
Implementation of Medicare Part D
Aging population
Changes in economic conditions
Health care cost inflation (technology)
Federal policy changes and Medicaid reform initiatives
Impact of low reimbursement on provider participation
Managed care penetration by geographic area and population type
Legislative initiatives/priorities
Budgetary/resource restraints
Growing emphasis on cost containment and program integrity

Anticipated Changes To Service Area Products and Services

The Department will be required to develop and implement certain activities following the implementation of the Medicare Part D benefit.
Application of managed care principles in the provision of long-term care services will have a significant impact on this population.
The Department will have to implement changes in services as a result of Medicaid reform.
The Department will have to implement operational changes to comply with national standards and advances in information technology.

Service Area Financial Summary

The Medicaid program is funded with a mixture of state and federal funds. The current match rate for Virginia is 50% state and 50% federal funds. The state match for the Medicaid program comes from a combination of the funding from the state General Fund, the Virginia Health Care Fund, and a small portion of the FAMIS trust Fund. The federal funds come from the federal Centers for Medicare & Medicaid Services

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Base Budget	$1,650,624,011	$2,275,551,782	$1,650,624,011	$2,275,551,782
Changes To Base	($304,915,857)	($470,796,767)	($177,497,900)	($331,705,422)
SERVICE AREA TOTAL	**$1,345,708,154**	**$1,804,755,015**	**$1,473,126,111**	**$1,943,846,360**

Service Area Objectives, Measures, and Strategies

Objective 45609.01

Facilitate access to member healthcare services

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to enhance the delivery of health care services and increase access to care.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45609.01.01**

  Number (percent) of eligible persons who are enrolled

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:
  Enrollment data (eligibility file) and external census data

Objective 45609.01 Has the Following Strategies:

- Work with local departments of social services to ensure eligible persons are enrolled.

  Monitor availability and utilization of services to ensure access.

  Develop and implement programmatic changes to address problem areas.

Objective 45609.02

Build and retain a sufficient network of diverse providers to deliver covered services

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will ensure enrollees can access services from providers.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services.)

- Promote better health outcomes through prevention-based strategies and improved quality of care.

  (Promote better health outcomes through prevention-based strategies and improved quality of care. Council on Virginia's Future Objective.)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45609.02.02**

  Ratio of recipient to provider by subtype and locality

  Measure Type: Output **Measure Frequency:** Every Six Months

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:
  Enrollment data (eligibility file) and provider file

Objective 45609.02 Has the Following Strategies:

- Identify and target regional areas where provider ratios are unfavorable.
- Review and, if required, implement new policies to assist in increasing provider participation.
- Implement a website with provider enrollment information.

Objective 45609.03

Enhance current systems that monitor quality assurance and program integrity

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will help to ensure the Medicaid program is as efficient as possible and is protected from fraud and abuse.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (To be recognized as the best-managed state in the nation.)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.)

This Objective Has The Following Measure(s):

- **Measure 45609.03.03**

  Frequency of inappropriate billing practices

  Measure Type: Output **Measure Frequency:** Quarterly

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:
  Source: Claims data and provider file information

Objective 45609.03 Has the Following Strategies:

- Identify and target potentially inappropriate billing by providers.
- Review and, if required, implement new policies and/or programs to reduce inappropriate billing.
- Increase use of CS-SARS to identify provider fraud and abuse.

- Refer potential fraud cases to the Medicaid Fraud Control Unit.

Objective 45609.04

Build and sustain an effective and innovative operation that utilizes technology and industry standards

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to improve operational efficiencies.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (To be recognized as the best-managed state in the nation.)
- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.)

This Objective Has The Following Measure(s):

- **Measure 45609.04.04**

  Timeliness and accuracy of claims processing

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: To be determined

  Measure Target: 100% of error-free claims are paid in 30 days

  Measure Source and Calculation:
  Source: Claims data

Objective 45609.04 Has the Following Strategies:

- Identify and target potentially inefficient billing procedures.
- Educate providers on common billing errors.
- Review and, if required, implement new policies and/or procedures to reduce inappropriate billing.

Objective 45609.05

Improve the quality, coordination of care and associated health outcomes to Medicaid/FAMIS participants diagnosed with asthma, diabetes, congestive heart failure and coronary artery disease

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to prevent costly medical procedures and improve quality of care.

This Objective Supports the Following Agency Goals:

- Promote better health outcomes through prevention-based strategies and improved quality of care.

  (Promote better health outcomes through prevention-based strategies and improved quality of care. Council on Virginia's Future Objective.)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45609.05.05**
  HEDIS measures

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:
  HEDIS data, claims data and encounter data

Objective 45609.05 Has the Following Strategies:

- Contract with a disease management program administrator (DMPA) to implement and administer the disease management program.
- Identify, evaluate, and manage the targeted disease state(s) as well as all co-morbid conditions of all participants included in the project.
- Develop strategies, including the development of outreach campaigns, designed to significantly increase knowledge of the program.

Objective 45609.06

Increase access to and utilization of high quality dental care services

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to enhance the delivery of healthcare services and increase access to care.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

This Objective Has The Following Measure(s):

- **Measure 45609.06.06**
  Percentage of Medicaid children receiving dental services

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: For FFY 2003 approximately 466,705 Medicaid enrollees over the age of three and under the age of 21 years were eligible for dental services and the percentage of Medicaid children receiving dental care was approximately 22%.

  Measure Target: 40% for FY 2007

  Measure Source and Calculation:
  Encounter data submissions

Objective 45609.06 Has the Following Strategies:

- Implement the Smiles For Children Dental Program effective July 1, 2005 that is administered by a Dental Benefits Administrator.
- Expand the Department's dental provider network, including specialists.

- Develop strategies, including the development of outreach campaigns, designed to significantly increase Medicaid/FAMIS Plus and FAMIS enrollee utilization of pediatric dental services.

Objective 45609.07

Ensure access to prenatal care for pregnant Medicaid recipients

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to ensure the effective delivery of covered healthcare services.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

This Objective Has The Following Measure(s):

- **Measure 45609.07.07**

  Number of pregnant women receiving prenatal visits by the second trimester

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: 77% for CY 2004

  Measure Target: 81% by FY 2008

  Measure Source and Calculation:
  EQRO study

Objective 45609.07 Has the Following Strategies:

- Develop approaches that will publicize the availability of Medicaid for eligible women so that a higher percentage can begin appropriate prenatal care in their first trimester.
- Streamline Medicaid's administrative and enrollment practices and provide an expedited eligibility process for pregnant women and process their applications within 10 days.

Objective 45609.08

Increase the percentage of Medicaid children who are fully immunized by age two

DMAS serves 660,000 persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to improve the level of preventive care and quality of life for young children.

This Objective Supports the Following Agency Goals:

- Promote better health outcomes through prevention-based strategies and improved quality of care.

This Objective Has The Following Measure(s):

- **Measure 45609.08.08**

  Number of two year olds fully immunized

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: 89% as of FY 2004

  Measure Target: 90% by FY 2008

  Measure Source and Calculation:

  Data Source: Claims data; CMS 416 report; comparable data from contracted managed care organizations; HEDIS data

Objective 45609.08 Has the Following Strategies:

- Track the number of children receiving necessary immunizations.
- Develop education efforts to remind providers of the importance of regular checkups, immunizations, and the need to coordinate patient information flow.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Long-Term Care Services (45610)

Service Area Background Information

Service Area Description

This service area provides access to a system of high-quality long-term care services to the elderly and persons with disabilities to ensure health, safety, and well being.

Service Area Alignment to Mission

By assisting adults and persons with disabilities to obtain long-term care we provide access to high-quality and cost-effective healthcare to meet their needs

Service Area Statutory Authority

Title 32.1 Chapter Code of Virginia

Service Area Customer Base

Customer(s)	Served	Potential
Clients / Beneficiaries· Low-income, Aged, and Disabled Virginians	44,835	0

Anticipated Changes In Service Area Customer Base

In fiscal year 2004, the Virginia Medicaid program provided nursing home care for 27,471 individuals, home and community-based care for 17,083 individuals, and private community inpatient mental retardation services for 281 individuals.

Due to the aging of the baby-boom population, an increasing number of persons with chronic conditions and those with developmental disabilities (including mental retardation), and an increase in the number of non-state intermediate care facilities for the mentally retarded (ICFs/MR), the Department anticipates the number of customers receiving long-term care services to rapidly increase over the next 15-20 years

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Long-Term Care & Waiver Programs – Nursing home Care; Home and Community-Based Services

Factors Impacting Service Area Products and Services

Inadequate reimbursement levels will diminish the number of available providers at both the institutional and community level. When combined with the general growth of the aging and disabled populations, these factors will exert greater pressures on the service delivery system.

Anticipated Changes To Service Area Products and Services

We anticipate an expansion of community-based care services to address the growing numbers of persons who will likely seek Medicaid-financed long-term care services. This strategy will be used to provide for more efficient use of long-term care services

Service Area Financial Summary

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Base Budget	$49,607,580	$49,608,580	$49,607,580	$49,608,580
Changes To Base	$609,974,574	$609,973,574	$638,031,548	$638,030,548
SERVICE AREA TOTAL	**$659,582,154**	**$659,582,154**	**$687,639,128**	**$687,639,128**

Service Area Objectives, Measures, and Strategies

Objective 45610.01

Decrease the number of persons entering institutional care through the use of home and community-based waiver services

Given the high and increasing cost of institutional care, DMAS will need to strengthen strategies to limit the number of persons who rely on this type of care through Medicaid.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services.)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45610.01.01**

  Number of persons entering long-term care as a percentage of persons screened for that care

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: FY 2005 – Approximately 62%

  Measure Target: FY 2007 - 52%

  Measure Source and Calculation:
  Agency's data systems – VaMMIS and PAS

Objective 45610.01 Has the Following Strategies:

- Develop a comprehensive automated UAI database that captures caregiver information and can be shared across agencies.
- Conduct standardized training for PAS teams on the availability and appropriate use of DMAS' home and community based care waivers.

Objective 45610.02

Ensure access to home and community-based services is provided only to those persons who meet the functional level of care criteria and who utilize the services to which they have been given access

Presently, DMAS believes that some waiver recipients are using their access to waiver services solely as a route to other Medicaid services (e.g., prescription drug coverage), for which they would not otherwise be eligible but for their enrollment in the waiver program.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45610.02.02**

  The percentage of people who are moved off of the waiver programs due to inappropriate access

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: FY 2005 - TBD

  Measure Target: Reduce by 10 percent the number of people with inappropriate access to the waivers.

  Measure Source and Calculation:
  Agency data systems – VaMMIS and WVMI

Objective 45610.02 Has the Following Strategies:

- Train staff to use VaMMIS for purposes of identifying inappropriate waiver use.
- Establish a process to notify and remove persons from the waiver programs who are inappropriately using these services.

Objective 45610.03

Establish the use of managed care as a service delivery model within the long-term care environment

There has been a longstanding belief that appropriate services can be delivered better at the appropriate time through the use of managed care. Presently most all long-term care services are paid for through fee-for-service.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45610.03.03**

  Number of long-term care recipients who are in managed care for their acute and long-term care needs

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: FY 2005 – 0.4%

  Measure Target: 2.5% for FY 2008

  Measure Source and Calculation:

  Source: Agency data system – VaMMIS

  Calculation:
  Number of individuals receiving long term care services through managed care divided by the total number of individuals eligible for long term care services

Objective 45610.03 Has the Following Strategies:

- Develop request for proposal (RFP).
- Meet with stakeholders to get buy-in.
- Design the program.
- Implement the program.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements to Acute Care Hospitals Providing Charity Care in Excess of the Median Level of Charity Care Costs (45901)

Service Area Background Information

Service Area Description

The purpose of the Indigent Health Care Trust Fund is to equalize the burden of charity care among non-state-owned hospitals, and to reimburse those among these hospitals with high charity care for part of this cost. Note: VCU and UVA hospitals are not included in the trust fund as they are state-affiliated facilities.

Service Area Alignment to Mission

By increasing the funding available for charity care, the Indigent Health Care Trust Fund (IHCTF) increases access to health care for Virginians who qualify under the IHCTF charity care criteria.

Service Area Statutory Authority

The ICHTF was created and is authorized by the Code of Virginia § 32.1-332 et seq. There is no other statutory or regulatory authority governing the IHCTF.

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	0	0

Anticipated Changes In Service Area Customer Base

The number of uninsured persons below the poverty level is affected by a number of factors, and DMAS does not forecast changes in this number. The Trust Fund's operation is not affected by changes in the customer base. The amount it collects from hospitals, and the amount it pays to other hospitals is fixed by state law, and is not affected by changes in the customer base.

Service Area Partners

Advocacy groups

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Financial Services) – DMAS determines the amount individual hospitals pay to or receive from the Trust Fund, and collects and pays these amounts.

Factors Impacting Service Area Products and Services

Changes in the Virginia economy and in employers' propensity to offer health insurance to employees affects the number of persons who may need to depend on charity care that is partially funded by the Trust Fund. However, the operation of the Trust Fund would not be directly affected by such a change.

Anticipated Changes To Service Area Products and Services

None

Service Area Financial Summary

Funding for the IHCTF comes from assessments billed to hospitals and general fund appropriations. For each of FY 2007 and 2008, the hospital funds appropriated are $5 million, and the general funds are $4,285,831. The hospital funds are an estimate, as the final amount depends on the application of a formula to actual hospital data each year. The formula determines which hospitals pay into the IHCTF, and which hospitals will be recipients of the funds.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Base Budget	$4,285,831	$5,000,000	$4,285,831	$5,000,000
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$4,285,831**	**$5,000,000**	**$4,285,831**	**$5,000,000**

Service Area Objectives, Measures, and Strategies

Objective 45901.01

Fund a portion of the charity care provided by Virginia hospitals

There are many persons in Virginia who are medically indigent. While the Trust Fund cannot pay for all the care they need, this goal is to reduce the burden on hospitals by paying for a portion of it.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services.)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 45901.01.01**

  Dollars paid to hospitals

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: $9,285,831

  Measure Target: $9,285,831

  Measure Source and Calculation:
  Source: DMAS operational reporting

Objective 45901.01 Has the Following Strategies:

- Continue to collect and pay funds as required by state law.

Service Area Background Information

Service Area Description

This service pays for 30 minutes of personal care (at $3/day per eligible recipient), for eligible people who receive an Auxiliary Grant. This is a State-only program. The Auxiliary Grant is the state supplement to Supplemental Security Income (SSI), which is paid to eligible individuals who reside in assisted living facilities.

Service Area Alignment to Mission

By assisting people to get additional personal care, we help them get access to health care services.

Service Area Statutory Authority

12VAC30-120-460: Outlines regular assisted living and gives eligibility requirements.

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	1,579	5,858

Anticipated Changes In Service Area Customer Base

When increases in the Auxiliary Grant are approved, more people could be eligible for Regular Assisted Living services. Increases in the auxiliary grant rate above the normal inflation adjustment are normally authorized through the Appropriation Act.

Service Area Partners

Advocacy groups

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Long-Term Care and Waiver Programs – Long-Term Care Healthcare Services
- Operations (Program Integrity) – Utilization Review
- Provider Enrollment, Services and Reimbursement – Claims Payments

Factors Impacting Service Area Products and Services

The number of providers could be a factor in the level and quality of care delivered

Anticipated Changes To Service Area Products and Services

None

Service Area Financial Summary

Financial Summary

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Base Budget	$1,612,952	$0	$1,612,952	$0
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$1,612,952**	**$0**	**$1,612,952**	**$0**

Service Area Objectives, Measures, and Strategies

Objective 46105.01

Improve the efficiency of the operation of the regular assisted living (RAL) program

Timely payments need to be made through VaMMIS for RAL recipients who transition between regular assisted living facilities and nursing facilities. The current reimbursement is not sufficient to pay for 30 minutes of personal care. Therefore the program needs to be evaluated and options must be presented to decision makers as to potential modifications to the regular assisted living program and how it interacts with other programs for the target population.

This Objective Supports the Following Agency Goals:

- Enhance the delivery of health care services by improving communication and relationships with customers and partners.

  (Enhance the delivery of healthcare services by improving communication and relationships with customers and partners.)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 46105.01.01**

  The number of claims that are paid within established time frames through VaMMIS claims processing

  Measure Type: Output **Measure Frequency:** Monthly

  Measure Baseline: 99% (2005)

  Measure Target: 100% paid timely by July 1, 2006

  Measure Source and Calculation:

  The data for regular assisted living and nursing facility payments will be captured from VaMMIS and compared to financial transactions currently being processed by the Program Operations Division for regular assisted living and nursing facility residents who transition between these two levels of care. Data will be calculated on a statewide basis.

Objective 46105.01 Has the Following Strategies:

- Program VaMMIS to ensure appropriate payments for regular assisted living and nursing facility residents who transition between regular assisted living and nursing facilities.
- DMAS should work with DSS to evaluate the RAL program and how it interacts with the Auxiliary Grant program and provide policy options to decision makers to improve the effectiveness of the provision of services to this population.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements to Localities for Residents Covered by the State and Local Hospitalization Program (46401)

Service Area Background Information

Service Area Description

This service area provides coverage for inpatient and outpatient hospitalization, ambulatory surgical centers and local health department clinic visits to eligible, indigent Virginians who are not eligible for Medicaid. A person may be eligible for the State and Local Hospitalization (SLH) Program whether employed or unemployed, insured or uninsured, if the person meets the income and resource criteria established for the program. SLH is not an entitlement program. Once a locality's funds are exhausted, no further benefits are offered until the next year's allocation is received.

Service Area Alignment to Mission

Individuals determined eligible for services under the program are provided access to high quality and cost effective health care services

Service Area Statutory Authority

Title 32.1, Chapter 12, Code of Virginia

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	6,101	12,789

Anticipated Changes In Service Area Customer Base

The number of recipients served through SLH has declined 11 percent over the past five years. This trend is likely to continue due to the rising cost of medical services and the capped level of funding in the program

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Special Programs – Coverage for Inpatient and Outpatient Hospitalization, Ambulatory Surgical Centers and Health Department Clinic Visits
- Operations (Financial Services) – Rate Setting; Calculation of Locality Allocations, Billing Localities and Collecting Locality Share
- Operations (Provider Enrollment, Services and Reimbursement) – Claims Processing

Factors Impacting Service Area Products and Services

The following factors will impact the services provided within this service area:
Limited funding for the program, which has not increased since the inception of the SLH program in FY90
Health care cost inflation
Implementation of Diagnostic Related Groups (DRG – a reimbursement payment methodology) in FY04 resulted in higher reimbursements per hospitalization. Therefore, fewer clients were able to receive services

Anticipated Changes To Service Area Products and Services

Regulatory changes are anticipated that will remove the eligibility determination requirement that bases the income and resource methodology on the former cash payment program Aid to Dependent Children (ADC). This policy is cumbersome for the Local Department of Social Services workers who determine eligibility, as ADC policy is no longer in existence. Additional policy changes are anticipated that will allow women determined eligible for limited Medicaid coverage under Family Planning Services to also be evaluated and enrolled in SLH. Currently, anyone eligible for Medicaid cannot be enrolled in SLH.

Service Area Financial Summary

The SLH program is financed entirely by state and local funds with the state providing at least 75% of the cost by allocating the amount of funds appropriated to each locality on the basis of current estimated demand for covered services. Funds allocated to a locality can be used to pay for services provided to residents of that locality only.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Base Budget	$10,865,779	$2,800,000	$10,865,779	$2,800,000
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$10,865,779**	**$2,800,000**	**$10,865,779**	**$2,800,000**

Service Area Objectives, Measures, and Strategies

Objective 46401.01

Ensure transactions are processed in an accurate and timely manner

Accurate and timely processes prevent costly rework.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (To be recognized as the best-managed state in the nation.)
- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.)

This Objective Has The Following Measure(s):

- **Measure 46401.01.01**

  Percent of claims paid within 30 days of receipt of the budget being loaded into VaMMIS

  Measure Type: Output **Measure Frequency:** Monthly

  Measure Baseline: To be determined

  Measure Target: 100% of claims are paid on time within 30 days of receipt.

  Measure Source and Calculation:
  Source: Currently there is no report that will capture this data in the Medicaid Management Information System (VaMMIS) . A report will be developed to capture the date the claim is received and the date the claim is processed.

  Calculation:
  Number of claims received / number paid within 30 days.

Objective 46401.01 Has the Following Strategies:

- Examine the billing instructions and the SLH manual for improvement opportunities.

Service Area Background Information

Service Area Description

This service area ensures that HIV clients are able to maintain their medication protocol. The program provides reimbursement for health insurance premium payments to ensure that those approved individuals are able to maintain and utilize their private health insurance.

In order to qualify an individual must be 1) a resident of Virginia, 2) able to provide documentation from a physician verifying disability within three months due to HIV+ diagnosis, and 3) eligible for and have availability of continuing health insurance. DMAS determines eligibility for the program and assumes the responsibility of providing health insurance premium payment in a timely manner

Service Area Alignment to Mission

By providing financial assistance for recipients' health insurance premiums, the program enables recipients to maintain maximum comprehensive health care benefits and deflect the expenses away from the Medicaid program. If these individuals do not maintain their private health insurance coverage they will likely become Medicaid eligible due to the significant costs for HIV pharmacy products.

Service Area Statutory Authority

Code of Virginia § 32.1-321.2 through 32.1-321.4,and § 63.1-124

Service Area Customer Base

Customer(s)	Served	Potential
Clients / Beneficiaries – Low-income, aged, or disabled Virginians	78	0

Anticipated Changes In Service Area Customer Base

The Department expects the number of eligible enrollees to increase. There are many individuals who are already eligible, but have not heard of the program nor applied for it because their case managers were aware of the waiting list. The waiting list is necessary due to the capped amount of funding.

Service Area Partners

Advocacy groups

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

State government officials

Service Area Products and Services

- Special Programs – financial assistance for health insurance premiums

Factors Impacting Service Area Products and Services

The services provided by the HIV Unit are extremely important to eligible enrollees and is limited only by funding options. There has always been a waiting list and the funding for this area needs to increase on an annual basis. There is a growing need for insurance continuation for this population as the drug therapies improve. Complicating this situation is the fact that premiums for commercial insurance have been increasing yearly at double- digit rates.

Anticipated Changes To Service Area Products and Services

The Department does not anticipate any changes to the products and services.

Service Area Financial Summary

The HIV Premium Assistance Program is funded with 100% state General Funds.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Base Budget	$556,702	$0	$556,702	$0
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$556,702**	**$0**	**$556,702**	**$0**

Service Area Objectives, Measures, and Strategies

Objective 46403.01

Ensure that HIV-disabled individuals who are not Medicaid eligible maintain their medical and pharmacy coverage

It is important to ensure enrollees' health insurance premiums are paid to avoid an interruption in coverage. This also helps to track the status of the effects of the virus.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

- Enhance the delivery of health care services by improving communication and relationships with customers and partners.

This Objective Has The Following Measure(s):

- **Measure 46403.01.01**

  Percentage of insurance premium payments accurately paid on time for enrolled and eligible individuals

  Measure Type: Output **Measure Frequency:** Other

  Measure Baseline: FY 2005-TBD

  Measure Target: 100% in FY 2007

  Measure Source and Calculation:

  Source: The data for premium assistance payments are extracted from the enrollees' applications and financial calculations are determined by figures provided on the applications in accordance with acceptable guidelines.

Objective 46403.01 Has the Following Strategies:

- Pay premiums for eligible persons on time and accurately
- Coordinate with AIDS Service Organizations and health clinics to implement and maintain an earlier application response time.

Objective 46403.02

Maximize the potential of the program to cover as many eligible individuals as possible within available funding

Maximize the potential of the program to cover as many eligible individuals as possible within available funding.
Enrollment in this program provides vital continuing healthcare for eligible individuals at a lower cost to the state. Alternate wording from a previous version: Enrolled customers are ensured of a quality of life as long as they live with the chronic and usually fatal disease they have contracted.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

This Objective Has The Following Measure(s):

- **Measure 46403.02.02**

  Percent of available funds expended

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: For Fiscal year 2005 approximately 99.1% of the annual appropriation was expended

  Measure Target: For FY 2007, spend 99% or greater of the annual appropriation

  Measure Source and Calculation:

  Source: CARS (expenditure tracking system)
  Calculation: total expenditures / appropriation

Service Area Plan

Department Of Medical Assistance Services

Reimbursements from the Uninsured Medical Catastrophe Fund (46405)

Service Area Background Information

Service Area Description

This service area provides payment for medical services to eligible, uninsured Virginians diagnosed with a life-threatening medical catastrophe. Eligibility is based on income, legal residency in the Commonwealth of Virginia, life threatening injury or illness and an approved treatment plan. Applications are taken on a first come, first served basis.

Service Area Alignment to Mission

Individuals determined eligible for services under the program are provided access to life-saving health care services.

Service Area Statutory Authority

Code of Virginia §32.1-324.3 and § 32.1-325

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	6	0

Anticipated Changes In Service Area Customer Base

With a new, dedicated staff position for this program, current initiatives to streamline the regulations and application process, and additional funding provided for fiscal year 2006, it is anticipated that the number of individuals served through the Uninsured Medical Catastrophe Fund will increase in future years to the extent that funding is available

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Special programs – Life-saving health care services based on Medicaid rates
- Operations (Enrollment and Member Services) – Determine eligibility, approve treatment plan, and determine treatment plan costs.
- Operations (Provider Enrollment, Services and Reimbursement) – Contract with providers for services approved on the treatment plan; verify services rendered and initiate payment to the provider.

Factors Impacting Service Area Products and Services

There a number of administrative and operational factors that affect the products and services of the UMCF, including application requirements, provider agreements and requirements, payment methodology, regulatory restrictions and limited funding. The Department intends to streamline the administrative/operational aspects of the program to make it more effective and less difficult to administer

Anticipated Changes To Service Area Products and Services

A dedicated staff person was recently hired to review and analyze program barriers, and to develop recommendations from workgroups and interested advocacy groups to streamline current processes and implement improvements. Program information sheets disseminated to advocacy groups and available on the Internet will be updated to clarify the current program requirements that have resulted in confusion with services received prior to a signed Provider Agreement.

Service Area Financial Summary

The program was funded entirely with private contributions and donations until FY 06 when the General Assembly allocated $125,000 in one time funding for the program. These funds were placed in DMAS' administrative budget to be transferred to the UMCF.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$0	$0	$0	$0
Changes To Base	$0	$0	$0	$0
SERVICE AREA TOTAL	**$0**	**$0**	**$0**	**$0**

Service Area Objectives, Measures, and Strategies

Objective 46405.01

Facilitate access to health care services to qualified uninsured Virginians who have been diagnosed with a life-threatening injury or illness

Uninsured individuals cannot always access required medical services to treat life-threatening injuries or illness. This program allows eligible individuals to receive medical treatment for a condition that otherwise left untreated, could result in death.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services.)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 46405.01.01**

  Number of applications approved

  Measure Type: Output **Measure Frequency:** Monthly

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:

  Source: Initial applications and approval/denial documents
  Calculation: Number of applications approved

- **Measure 46405.01.02**

  Percent of necessary services that are adequately represented /documented on the treatment plan

  Measure Type: Outcome **Measure Frequency:** Other

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:

  Source: Treatment plan checklist
  Calculation: Number of information fields properly completed / # of required information fields

Objective 46405.01 Has the Following Strategies:

- Review and streamline application processes to accommodate for the timeliness necessary for life-threatening conditions.
- Explore the creation of a pre-approved regional list of providers willing to provide treatment under the conditions of the UMCF.

- Educate and contact providers before a medical crisis occurs with information on both the UMCF and instructions to properly complete patient treatment plans in order to prevent costly delays.

Service Area Plan

Department Of Medical Assistance Services

Reimbursements for Medical Services Provided to Low-Income Children (46601)

Service Area Background Information

Service Area Description

The expansion of Medicaid eligibility for uninsured children from age 6 to 19 is part of Virginia's Title XXI program for uninsured children living below 200% of the federal poverty level (FPL). Prior to this expansion, children under age 6 could qualify for Medicaid benefits with family income up to 133% FPL but children from 6 to 19 would only qualify for Medicaid with income less than or equal to 100% FPL. Children from 6 to 19 with income between 100% FPL and 133% FPL might qualify for the FAMIS program instead; but this meant children in the same family would be enrolled in different programs and families would have to navigate two different systems of care. In September 2002, Virginia's Title XXI program was split into FAMIS for children 0 – 19 with income greater than Medicaid but less than or equal to 200% FPL; and the SCHIP Medicaid Expansion for children age 6 – 19 with income greater than 100% FPL but less than or equal to 133% FPL. Children covered by the SCHIP Medicaid Expansion receive full Medicaid benefits but are funded through Title XXI at a lower state-matching rate Than Title XIX (Medicaid).

In 2004, The Virginia General Assembly renamed Medicaid for children, including the SCHIP Medicaid Expansion program, to FAMIS Plus.

Service Area Alignment to Mission

The SCHIP Medicaid Expansion carries out the mission of DMAS by providing access to a comprehensive system of high quality and cost effective health care services to uninsured children age 6 to 19 with income between 100% FPL and 133% FPL.

Service Area Statutory Authority

CFR: 42 part 457

Code of Virginia §32.1-351

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients: Uninsured children age 6 to 19 with family income greater than 100% FPL and less than or equal to 133% FPL	54,880	0

Anticipated Changes In Service Area Customer Base

The customer base of children eligible for the SCHIP Medicaid Expansion program is likely to remain approximately the same for the next several years. Factors that could affect the number of customers would include a downturn in the Virginia economy, private insurance market forces that result in an increase in rates of uninsurance, a significant increase in the 6 to 19 population, or policy changes affecting program eligibility

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Federal agencies

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- SCHIP Medicaid Expansion
  Coverage for comprehensive health care services through managed care or fee-for-service
  Marketing and outreach to promote enrollment
  Application processing and enrollment
  Claims payment

Factors Impacting Service Area Products and Services

Federal and state appropriations and regulations impact the nature and scope of the services that can be provided through the SCHIP Medicaid Expansion. Unlike Medicaid, the SCHIP Expansion is not an entitlement program

Anticipated Changes To Service Area Products and Services

Congress must reauthorize Title XXI no later than 2007. It is likely the federal funding formula that determines Virginia's annual allotment will be revised.

Service Area Financial Summary

The Medicaid expansion program is covered with a mixture of state and federal funds. On the federal level this program is covered through the Title XXI SCHIP program that provides an enhanced federal match rate. The current match rate for Virginia is 35% state and 65% federal funds. The state match for the Medicaid expansion program comes from the state General Fund. The federal funds come from the federal Centers for Medicare & Medicaid Services.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Base Budget	$20,615,213	$39,772,726	$20,615,213	$39,772,726
Changes To Base	$2,720,827	$3,565,633	$5,238,050	$8,240,475
SERVICE AREA TOTAL	**$23,336,040**	**$43,338,359**	**$25,853,263**	**$48,013,201**

Service Area Objectives, Measures, and Strategies

Objective 46601.01

Enroll all eligible children in the SCHIP Medicaid Expansion program

While enrollment of eligible children in the SCHIP Medicaid Expansion program has increased dramatically, there are still thousands of uninsured children who could be covered and additional children who become uninsured every day. It is in the best interest of the children, their families and the Commonwealth to provide comprehensive health care coverage through the SCHIP Medicaid Expansion to this vulnerable population.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (Facilitate the development of public healthcare policies that promote access to care and the efficient, effective, innovative delivery of covered services)

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 46601.01.01**

  The percentage of eligible children enrolled in SCHIP Medicaid Expansion or FAMIS

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: As of July 1, 2005, 96% of estimated eligible children are enrolled in either FAMIS or FAMIS Plus.

  Measure Target: The enrollment target for the SCHIP Medicaid Expansion program will remain at 95% or better for FY 2006.

  Measure Source and Calculation:

  Data Source: Data from VaMMIS on the number of children enrolled in the SCHIP Medicaid Expansion on the first day of each month, following all cancellations that occur on the last day of each month, will be reported. This number will be combined with enrollment data for all children enrolled in FAMIS Plus (Medicaid) and FAMIS and compared to the number of children estimated to be eligible for publicly supported health insurance in Virginia for a percentage of overall enrollment.

  Calculation: Estimates of eligible children are calculated by a formula based on Census data, poverty rates by locality and results of the 2001 Health Access Survey conducted by the Virginia Health Care Foundation. This formula is evaluated periodically as current data become available.

Objective 46601.01 Has the Following Strategies:

- Develop and implement a general marketing campaign specifically designed to reach families with eligible children.
- Develop outreach activities and materials to reach traditionally "hard-to-reach" populations.
- Increase the use of technology to improve customer service for interested families and to facilitate application processing and enrollment.

Objective 46601.02

Increase utilization of appropriate preventive care by children enrolled in the SCHIP Medicaid Expansion

Approximately 55,000 children have been served through the SCHIP Medicaid expansion program in FY 2005. This objective will focus DMAS' efforts to improve health outcomes for children and reduce long-term health care costs by improving the timely and appropriate utilization of preventive health care services.

This Objective Supports the Following Agency Goals:

- Promote better health outcomes through prevention-based strategies and improved quality of care.
  (Promote better health outcomes through prevention-based strategies and improved quality of care.)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.
  (: Inspire and support Virginians toward healthy lives and strong and resilient families.)

This Objective Has The Following Measure(s):

- **Measure 46601.02.01**
  Routine pediatric dental care

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: In FFY 2003 approximately 466,705 Medicaid enrollees over the age of three and under the age of 21 years were eligible for dental services and the percentage of Medicaid children receiving dental care was approximately 22%.

  Measure Target: Utilization percentage at or beyond 40% for FY 2007

  Measure Source and Calculation:
  DMAS claims data are utilized to determine the number of children covered by FAMIS or FAMIS PLUS between the age of three and twenty-one receiving routine dental care visits. This number is divided by the number of children in this age group enrolled in the program.

- **Measure 46601.02.02**
  EPSDT well-child screenings

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: EPSDT well-child screenings Well-child screenings in FFY 2004 = Overall compliance rate for all eligible children on Medicaid was 56%. (47% for 6 – 9; 43% for 10 – 14; and 45% for 15 – 18).

  Measure Target: EPSDT well-child screenings – Well-child screenings for FFY 2008 = 80% overall compliance

  Measure Source and Calculation:
  DMAS contracts with Delmarva Foundation to study utilization of appropriate well child visits by the FAMIS population. Both administrative claims data from VaMMIS and medical record data are reviewed. The rate of 15-month-old children receiving the recommended number of well-child visits is determined by comparing the number of children in this age group who received six or more well-child visits since birth to the total number of 15-month-old children enrolled. The rate of 3 to 6 year old children receiving recommended well-child visits is determined by comparing the number of children in this age group receiving one or more well-child visits during the study period to the total number of 3 to 6 year old children.

Objective 46601.02 Has the Following Strategies:

- Promote utilization of EPSDT (well-child screenings) covered by Medicaid and remind providers of the importance of regular checkups, immunizations, and the coordination of information.
- Promote utilization of preventive pediatric dental visits by children covered by Medicaid.

Service Area Plan

Department Of Medical Assistance Services

Administrative and Support Services (49900)

Service Area Background Information

Service Area Description

This service area includes the manpower, overall administrative support, policy and research and contractual services necessary to successfully operate the Agency's programs and activities.

Service Area Alignment to Mission

By providing a system of administrative support to all the operational areas of the program, we are helping to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians.

Service Area Statutory Authority

Title 32.1, Chapters 9 &10, Code of VA: PL89-87m, as amended, Title 19, Social Security Act, Federal Code

Service Area Customer Base

Customer(s)	Served	Potential
Beneficiaries / Clients	852,549	0

Anticipated Changes In Service Area Customer Base

In order to better serve the increasing eligible population, there is a need to increase the Agency's maximum employment level to reduce our dependence on the use of hourly and contract personnel.

Service Area Partners

Advocacy groups

Service Area Partners

Boards and committees

Service Area Partners

Health care professionals, organizations, and facilities

Service Area Partners

Private business firms

Service Area Partners

State and local entities

Service Area Partners

State government officials

Service Area Products and Services

- Operations (Financial Services) – Budgeting & Contract Services
- Operations (Policy Analysis and Information Dissemination) – Communications and Legislative Liaison Services
- Operations (Information Management)
- Operations (Program Integrity) – Internal Audit Services
- Operations (Enrollment and Member Services; Provider Enrollment, Services and Reimbursement) – Appeals Services
- Operations (Financial Services) – Fiscal Services
- Administration – Human Resources Services & Training
- Operations (Program Integrity) – Quality Assurance Services
- Operations (Provider Enrollment, Services and Reimbursement) – Provider Reimbursement Services
- Operations (Policy Analysis and Information Dissemination) – Policy & Research Services

Factors Impacting Service Area Products and Services

Projects related to the work of DMAS operational areas determine the work that is performed in the administrative divisions. Because of this, changes in administrative services are the result of major operational projects, including the Medicare Prescription Drug Program, Medicaid Reform, Electronic Health Records, Disease Management Program, and the National Provider Identifier project.

Anticipated Changes To Service Area Products and Services

The administrative service area products and services are not expected to change dramatically. However, the Department must be flexible and adapt to new programs and priorities. Moreover, the agency's MEL needs to be increased in order to continue current programs and implement any new functions

Service Area Human Resources Summary

Service Area Human Resources Overview

Service Area Full-Time Equivalent (FTE) Position Summary

Effective Date:

Total Authorized Position level .....

Vacant Positions .....

Non-Classified (Filled).....

Full-Time Classified (Filled) .....

Part-Time Classified (Filled) .....

Faculty (Filled) .....

Wage .....

Contract Employees .....

Total Human Resource Level .....

Factors Impacting Service Area Human Resources

Anticipated Changes in Service Area Human Resources

Service Area Financial Summary

DMAS' administrative funding consists of federal funds and state general (GF) funds. There are also several small grants that are paid from non-general funds (NGF). For fiscal year 2006, $29.3 million in funding, or 39%, is from GF and $ 46.2 million, or 61%, in funding is from federal funds and other NGF.

In addition, DMAS manages the FAMIS administrative program. In fiscal year 2006, $2.4 million in funding is from GF, and $ 4.5 million in funding is from federal funds.

DMAS also serves as the pass-through agency for the transfer of federal funding to the Department of Social Services for Medicaid eligibility determinations. These amounts and smaller pass-throughs to four other state agencies are not in the base budget figures.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Base Budget	$31,715,960	$50,682,598	$31,715,960	$50,682,598
Changes To Base	$5,867,063	$9,487,507	$5,866,856	$7,163,894
SERVICE AREA TOTAL	**$37,583,023**	**$60,170,105**	**$37,582,816**	**$57,846,492**

Service Area Objectives, Measures, and Strategies

Objective 49900.01

Improve communication among employees throughout the agency

This objective will allow the department to develop more effective methods of communication within and between divisions that, in turn, will contribute towards ensuring a comprehensive system of high quality and cost effective health care services

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (To be recognized as the best-managed state in the nation.)
- Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.

  (Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.)

This Objective Has The Following Measure(s):

- **Measure 49900.01.01**

  The degree to which employees feel communications are effective (as measured by a survey)

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: To be determined by employee survey

  Measure Target: To be determined

  Measure Source and Calculation:

  The degree to which employees feel communications are effective (as measured by a survey).

Objective 49900.01 Has the Following Strategies:

- Design, administer and analyze the results of an employee survey.
- Implement a communication plan based on results of survey.
- Conduct a follow-up assessment of communication within the department six months after any changes.

Objective 49900.02

Recruit, develop and retain a skilled, diverse and adequately sized, professional workforce

A highly skilled and stable workforce is essential for meeting the goals and mission of the Department. To ensure such a workforce is in place, the Department needs a recruitment process that will attract the highest level of skilled candidates and retain these workers once hired. In addition, The Department needs a recognition program that contributes to a positive work environment and improves employee productivity.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (To be recognized as the best-managed state in the nation.)

- Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.

  (Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance)

This Objective Has The Following Measure(s):

- **Measure 49900.02.01**

  Employee turnover rate

  Measure Type: Outcome **Measure Frequency:** Quarterly

  Measure Baseline: 11.5% for FY 05

  Measure Target: 8.0% for FY 07

  Measure Source and Calculation:

  Recruitment and Selection Log Analysis and Human Resources Transaction Log Analysis

- **Measure 49900.02.02**

  The degree to which the awards and recognition program increases employee satisfaction

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:

  Employee Survey

- **Measure 49900.02.03**

  The types and numbers of pertinent training classes offered through the Human Resources Division

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:

  Employee Training Class Evaluations

Objective 49900.02 Has the Following Strategies:

- Redesign and implement an exit interview process that better captures reasons for employee resignations.
- Develop effective and consistent rewards, incentives and recognition to improve employee morale and better recognize outstanding performance.
- Design and implement a system to effectively train and develop staff.
- Design, administer and analyze the results of an employee survey.
- Revise the recognition program, as needed, based on survey results.
- Maintain a record of awards and analyze for consistency and cost between divisions.
- Prepare and analyze quarterly reports that include selection and turnover data as well as exit interview results.

Objective 49900.03

Safeguard and protect the assets of the agency, ensuring that incidents of fraud, waste and abuse are identified and reduced

The purpose of this goal is to protect taxpayer assets in the custody of DMAS and to optimize their employment through a system of controls designed to prevent, detect and eliminate financial and other irregularities such as waste, loss, and unauthorized use or misappropriation.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (To be recognized as the best-managed state in the nation.)
- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  (Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.)

This Objective Has The Following Measure(s):

- **Measure 49900.03.01**

  The number of incidents involving fraud, waste and abuse reported by the APA and other audit entities

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:

  Data Sources: Operational and administrative data, automated (e.g., agency systems, such as FACCS, Oracle, CARS) and un-automated, related to all DMAS operations; audit findings; Calculations: Raw count of the number of incidents

Objective 49900.03 Has the Following Strategies:

- Conduct concurrent audits of DMAS business processes (DMAS Internal Audit); thoroughly investigate all hot line tips.
- Follow through on findings of 1) annual audits of the DMAS financial statements and the DMAS system of internal control conducted by the Virginia Auditor of Public Accounts, 2) quarterly reviews of DMAS operations conducted by CMS and other Federal oversight agencies, and 3) DMAS concurrent audits.
- Strengthen the current system of internal controls designed to prevent waste, loss, unauthorized use and misappropriation of Agency resources.
- Perform periodic vulnerability assessments and implement process/system changes based on vulnerability assessment findings.
- Ensure adequate standards of business conduct are being observed and financial statements and reports comply with generally accepted business standards.
- Ensure the timely and accurate posting of data into Agency systems.

Objective 49900.04

Ensure programs are evaluated and monitored for operational effectiveness and efficiency

DMAS is under an obligation to Virginia taxpayers to operate its programs so as to maximize its use of

taxpayer provided resources while delivering the highest quality of care those resources will command.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (To be recognized as the best-managed state in the nation.)
- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.)

This Objective Has The Following Measure(s):

- **Measure 49900.04.05**

  The number of incidents involving operational inefficiency/ineffectiveness reported by audit entities

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: To be calculated based on prior fiscal year

  Measure Target: TBD

  Measure Source and Calculation:

  Data Source: Operational and administrative data, automated and manual, related to all DMAS operationsCalculation:

Objective 49900.04 Has the Following Strategies:

- Investigate Hotline tips and conduct concurrent audits.
- Follow through on annual audits of the DMAS programs conducted by the Virginia Auditor of Public Accounts.
- Perform regularly scheduled audits of program operations.

Objective 49900.05

Process transactions in a timely and accurate manner in accordance with all HIPAA standards

Transactions are to be promptly and accurately recorded and classified in accordance with Agency guidelines and are 100% compliant with HIPAA standards.

This Objective Supports the Following Agency Goals:

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  (To be recognized as the best-managed state in the nation.)
- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  (Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.)

This Objective Has The Following Measure(s):

- **Measure 49900.05.01**

  Percent of audited transactions processed within time standards

  Measure Type: Outcome **Measure Frequency:** Monthly

  Measure Baseline: To be determined

  Measure Target: To be determined

  Measure Source and Calculation:

  Data Source:
  Agency systems to include (but not limited to) CARS, MMIS, Oracle. Monthly reconciliation's and periodic audit sampling of transactions to test the timeliness of Agency processes.
  Calculation: Agency systems to include (but not limited to) CARS, MMIS, Oracle.

Objective 49900.05 Has the Following Strategies:

- Establish and communicate the appropriate authorization and execution of transactions in accordance with Agency guidelines and internal controls.
- Perform monthly reconciliation between general ledger accounts, subsidiary ledgers, source documentation, claim submissions, etc to determine improper and untimely recording of transactions; Agency staff should perform periodic review and testing of transactions to determine how long (timeliness) it takes for transactions to be processed – from receipt to classification in Agency systems..
- Implement and/or adjust procedures to prevent the recurrence of process inefficiencies based on the evaluation of monthly reconciliation's and periodic reviews.
- Increase productivity through process and technology improvement.
- Compare DMAS programs and policies against other best practices in the nation.
- Establish list of HIPAA transaction "Benchmarks."
- Analyze the results of DMAS comparison of standard against the established benchmark.
- Acknowledge compliance or improve standards based on results of comparison.

Objective 49900.06

To ensure that resources are used efficiently and programs are managed effectively, and in a manner consistent with applicable state and federal requirements

To ensure that resources are used efficiently and programs are managed effectively, and in a manner consistent with applicable state and federal requirements.

This Objective Supports the Following Agency Goals:

- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

This Objective Has The Following Measure(s):

- **Measure 49900.06.01**

  Percent of Governor's Management scorecard categories marked as meets expectations for the agency

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: 80%

  Measure Target: 100%

  Measure Source and Calculation:

  The Management Scorecard grades agencies on five criteria: Human Resource Management, Government Procurement, Financial Management, Technology, and Performance Management (the sixth, "Environmental & Historic Resource Stewardship" was not measured in 2005). The measure is calculated by taking the number of criteria where the agency scored "Meets Expectations" and dividing by five.